

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

1

14285

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14284

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN TB <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>Rt. 1, Box 2840</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Tyrone Elmer Addison</b>				4. DATE OF DEATH Month <b>October</b> Day <b>2</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>7/8/66</b>		9. AGE (In years last birthday) yrs <b>2</b>	IF UNDER 1 YEAR Months <b>25</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Olney, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Estelle L. Addison</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Montgomery</b> Address <b>Gen'l. Hospital records Olney, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure,</b> DUE TO <b>7730</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>etiology undetermined</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b>		EXAMINER'S NAME (Type) <b>Belden Reap, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>Oct. 3, 1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-5-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial.,</b>		23d. LOCATION (City or Town) (County) (State) <b>Sandy Spring, Md.</b>	
24. FUNERAL DIRECTOR <b>Rufus L. Suonder</b>				ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 6 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

14341

14342

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14286

CERTIFICATE OF DEATH

14285

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>Virginia</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN TB <b>45 min.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>			d. STREET ADDRESS <b>522 South Courthouse Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Murray Craven ALEXANDER</b>			4. DATE OF DEATH Month Day Year <b>October 30 1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>30 July 1912</b>		9. AGE (In years last birthday) <b>54</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Charlotte, North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Murray C. Alexander Sr</b>			14. MOTHER'S MAIDEN NAME <b>Margaret L. Smith</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>238-03-0339</b>	17. INFORMANT (Wife) <b>322 S. Court House</b> <b>Mrs. Doris B. Alexander Rd., Arlington, Va.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>30 October 1966</b> , to <b>30 October 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>30 October 1966</b> , and that death occurred <b>11:30 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>Raymond B. Johnson</i>			22b. DATE SIGNED <b>31 October 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Raymond B. Johnson LT MC USN</b>			22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2 Nov 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>		
24. FUNERAL DIRECTOR <i>W. G. Graft</i> <b>3901 N. Fairfax</b> <b>Arlington Funeral Home Arlington, Virginia</b>			25a. REC'D BY REGISTRAR DATE <b>NOV 2 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

14884

14884

Department

Virginia

Postoffice (Rural)

Arlington

Naval Hospital

202 South Commerce Road

Postoffice (Rural)

Delaware

Postoffice (Rural)

Delaware



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14287

CERTIFICATE OF DEATH

14286

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>6 Jefferson Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Anderson</u> Last <u>Anderson</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-68</u>
9. AGE (In years last birthday) <u>98</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Road Constructor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Denmark</u>
12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>  </u>	
14. MOTHER'S MAIDEN NAME <u>Carolina Thorgrimson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service) <u>  </u>	
16. SOCIAL SECURITY NO. <u>572 32 8548</u>		17. INFORMANT <u>Washington Sanitarium &amp; Hospital Records</u> Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X Ventricular Fibrillation</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (1) (this hospital) attended the deceased from <u>10-1</u> , 19 <u>66</u> , to <u>10-17</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>10-16</u> , 19 <u>66</u> , and that death occurred at <u>9 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>R. H. Sandstrom</u>		22b. DATE SIGNED <u>10-17-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. SANDSTROM</u>		22d. ADDRESS <u>7701 Carroll Ave TRK, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct 20, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dorset Lawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Los Angeles California</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>254 Carroll St NW Wash DC</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 18 1966</u>			

1938

1938

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/66

FOR STATE  
HEALTH DEPT

14288

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14287

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN TB <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville, 1511</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				d. STREET ADDRESS <b>13517 Sloan St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Carl</b> Last <b>Annis</b>			4. DATE OF DEATH Month <b>October</b> Day <b>7</b> Year <b>19 66</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/8/66</b>		9. AGE (In years last birthday) yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Bethesda, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James L. Annis</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Pound</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Father,</b> Address <b>James Annis 13517 Sloan St. Rockville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>492 X</b> IMMEDIATE CAUSE (a) <b>Acute interstitial pneumonitis</b> DUE TO (b) <b>of probable viral origin</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b>		EXAMINER'S NAME (Type) <b>Belden R. Reap</b>		22. DATE SIGNED <b>Oct. 7, 1966</b>		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Florida Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Florida</b>	
24. FUNERAL DIRECTOR <b>W. Glen Carter</b>		ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

6-223279

PAGE 1

7-20-81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14289					14288				
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>23 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Md.</b>					d. STREET ADDRESS <b>112 Forest Drive</b>				
3. NAME OF DECEASED (Type or print) <b>Lester John Auker</b>			First Middle Last		4. DATE OF DEATH <b>October 5 1966</b>		Month Day Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9 February 1901</b>		9. AGE (in years last birthday) <b>65 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile Tires</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Harry W. Auker</b>					14. MOTHER'S MAIDEN NAME <b>Nora Woodward</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1918-1920</b>		17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda, Maryland 20014</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory &amp; Cardiac arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular accident</b> DUE TO (c) <b>Chronic Myelogenous Leukemia</b>									INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>6 Days</b> <b>18 Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>September 12, 1966</b> , to <b>October 5, 1966</b> , that <del>the</del> (we) last saw the deceased alive on <b>October 5, 1966</b> , and that death occurred at <b>4:40 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Herbert E. Kann, Jr., MD.</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5 October 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Herbert E. Kann, Jr., MD.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>			23b. DATE THEREOF <b>Oct 7, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>(Ashes) Hillcrest Burial Park</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR <b>John J. Hafert</b>					ADDRESS <b>230 Balto Ave., Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**14290**

**CERTIFICATE OF DEATH**

**14289**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8502 16th St.</b>		d. STREET ADDRESS <b>8502 16th St.</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSE</b> Middle <b>EULOGIO</b> Last <b>AYALA</b>		4. DATE OF DEATH Month <b>10</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-7-77</b>
9. AGE (In years last birthday) <b>89</b> Yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired railroad engineer</b>		12. CITIZEN OF WHAT COUNTRY? <b>MEXICO</b>	
13. FATHER'S NAME <b>DIONISIO AYALA</b>		14. MOTHER'S MAIDEN NAME <b>THOMASA PEREZ</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>GUADALUPE A. SOUTER (daughter)</b>		Address <b>8502-16th St. Silver Sp. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4260</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cancer, urinary bladder</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , 19 to <b>Oct.</b> , 1966, that (I) (we) last saw the deceased alive on <b>10-3-1966</b> , and that death occurred at <b>2A</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>Irwin H. Ardham</b>		22b. DATE SIGNED <b>10-5-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>IRWIN H. ARDAM, M.D.</b>		22d. ADDRESS <b>1712 - I - St., N.W. WASH., D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>10-6-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	23d. LOCATION (City or town) (County) (State) <b>Silver Spring, Md.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawlers Sons</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 7 1966</b>	
ADDRESS <b>5130 Wisc Ave NW</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

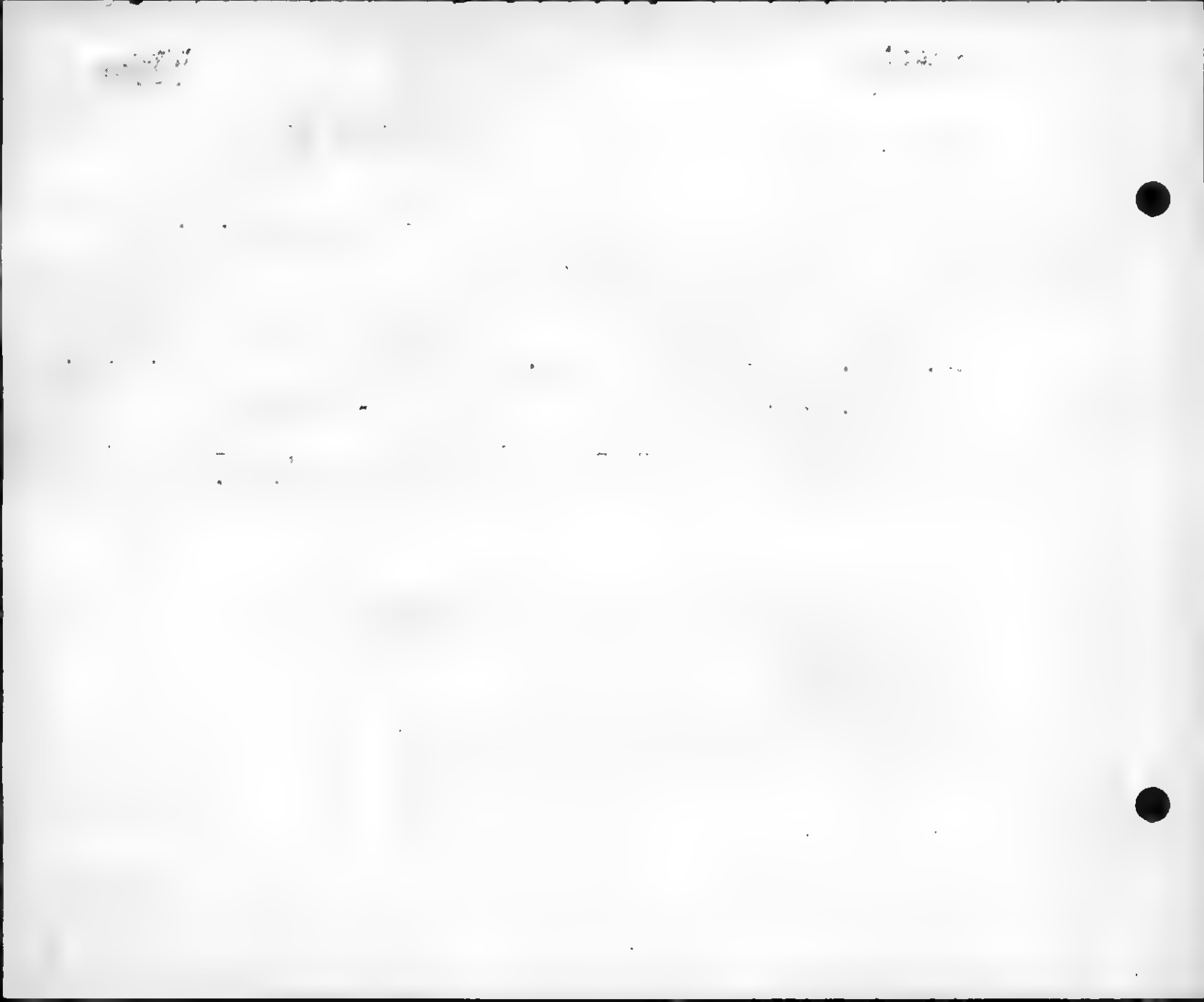
14291

CERTIFICATE OF DEATH

14290

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>xxxx</u> <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>3023 - 14 Street N. W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Mayer</u> Last <u>Baer</u>		4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-1887</u>
9 AGE (In years lost birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt. Clerk- Interior Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12 CIT ZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Alfred D. Baer</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Johnson</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WWI</u>		16 SOCIAL SECURITY NO. <u>578-50-8172</u>	
17. INFORMANT <u>Miss Elizabeth O. Baer-1348 Prichard St</u>		Address <u>Pittsburg, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Chronic Congestive HT. Failure</u>			19 WAS A. TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> , 19 <u>66</u> , to <u>10/4</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/4</u> , 19 <u>66</u> , and that death occurred at <u>12:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond T. Benack</u> M.D.		22b. DATE SIGNED <u>10/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack MD</u>		22d. ADDRESS <u>4115 Colie Drive, Wheaton MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>10/5/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chartiers Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Carnegie, Pennsylvania</u>
24. FUNERAL DIRECTOR <u>S.H. Hines Co. 2901-14th St. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 7 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

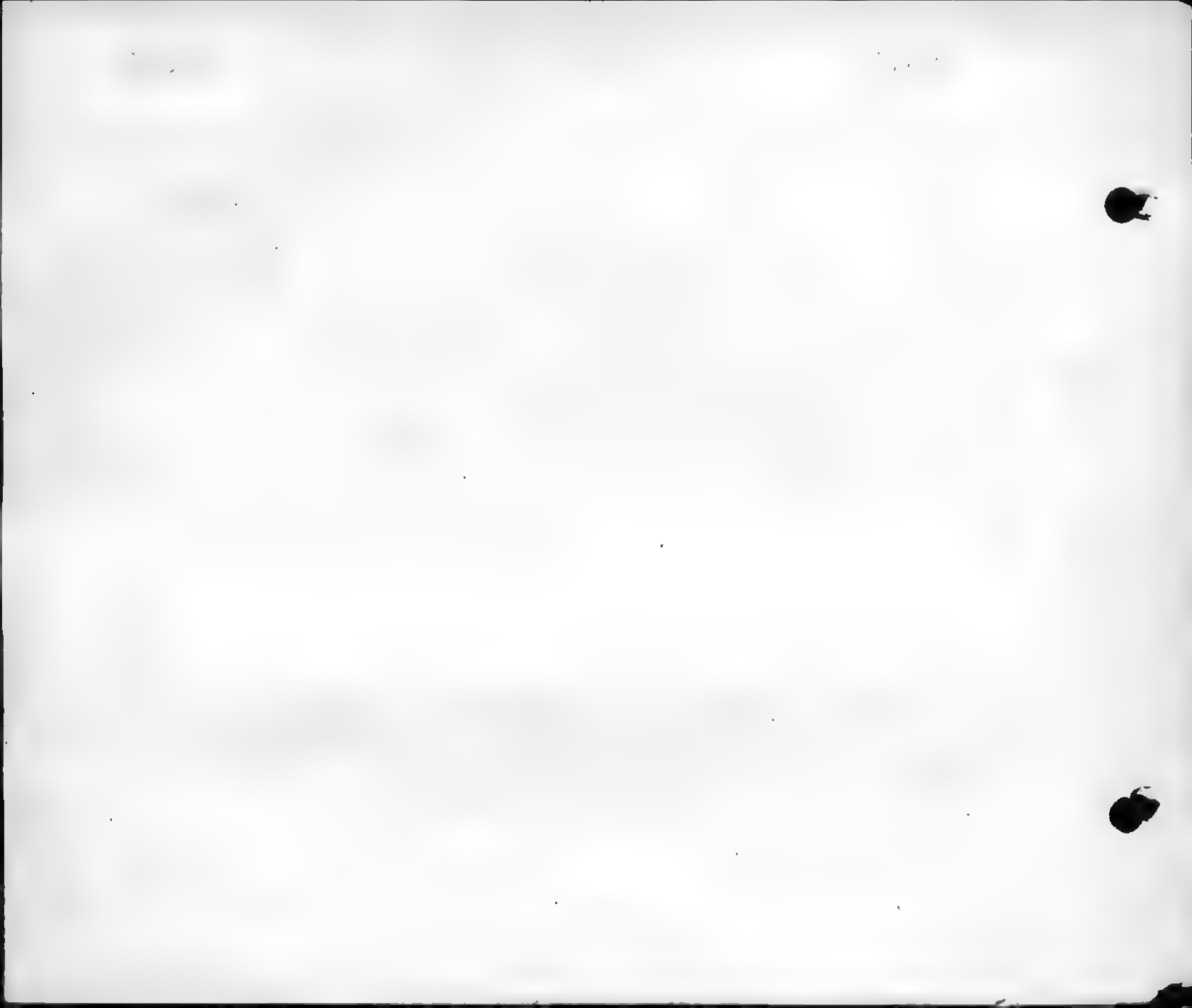


**UNITED STATES DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14292

14291

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakona Park</i>				c. LENGTH OF STAY IN 1b <i>1 year</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7300 Baltimore Ave</i>				d. STREET ADDRESS <i>7538 Eastern Ave. N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Margaret Suzanne Bailey</i>				4. DATE OF DEATH <i>Oct 4 1966</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 2, 1873</i>	
9. AGE (in years last birthday) <i>92 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Miner</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>Charles Co. Md.</i>	
13. FATHER'S NAME <i>Alexander Edelen</i>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mary B. Vuirbruchen (same as #2.)</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>							
4. DUE TO <i>Chronic Myocarditis</i> Undetermined							
(b) <i>Generalized Arterio-sclerosis</i> Undetermined							
DUE TO <i>Cerebro-sclerosis</i> Undetermined							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture left hip Oct 3, 1965</i>							
19. WAS AUTOPSY PERFORMED? * YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Fell in home</i>			
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <i>Oct 3 1965</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) <i>Washington</i> (County) (State) <i>D.C.</i>							
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1 1966</i> to <i>Oct 4 1966</i> , that (I) (we) last saw the deceased alive on <i>Oct 4 1966</i> , and that death occurred at <i>4:15 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>George L Ball</i>				22b. DATE SIGNED <i>Oct 4, 1966</i>			
22c. PHYSICIAN'S NAME (Type) <i>George L Ball</i>				22d. ADDRESS <i>10620 Georgia Ave. Silver Spring Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 8, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Frederick, Md. Co. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Frank Watters</i> ADDRESS <i>254 Carroll N.W. W.C.</i>				25. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	
				DATE <i>OCT 10 1966</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

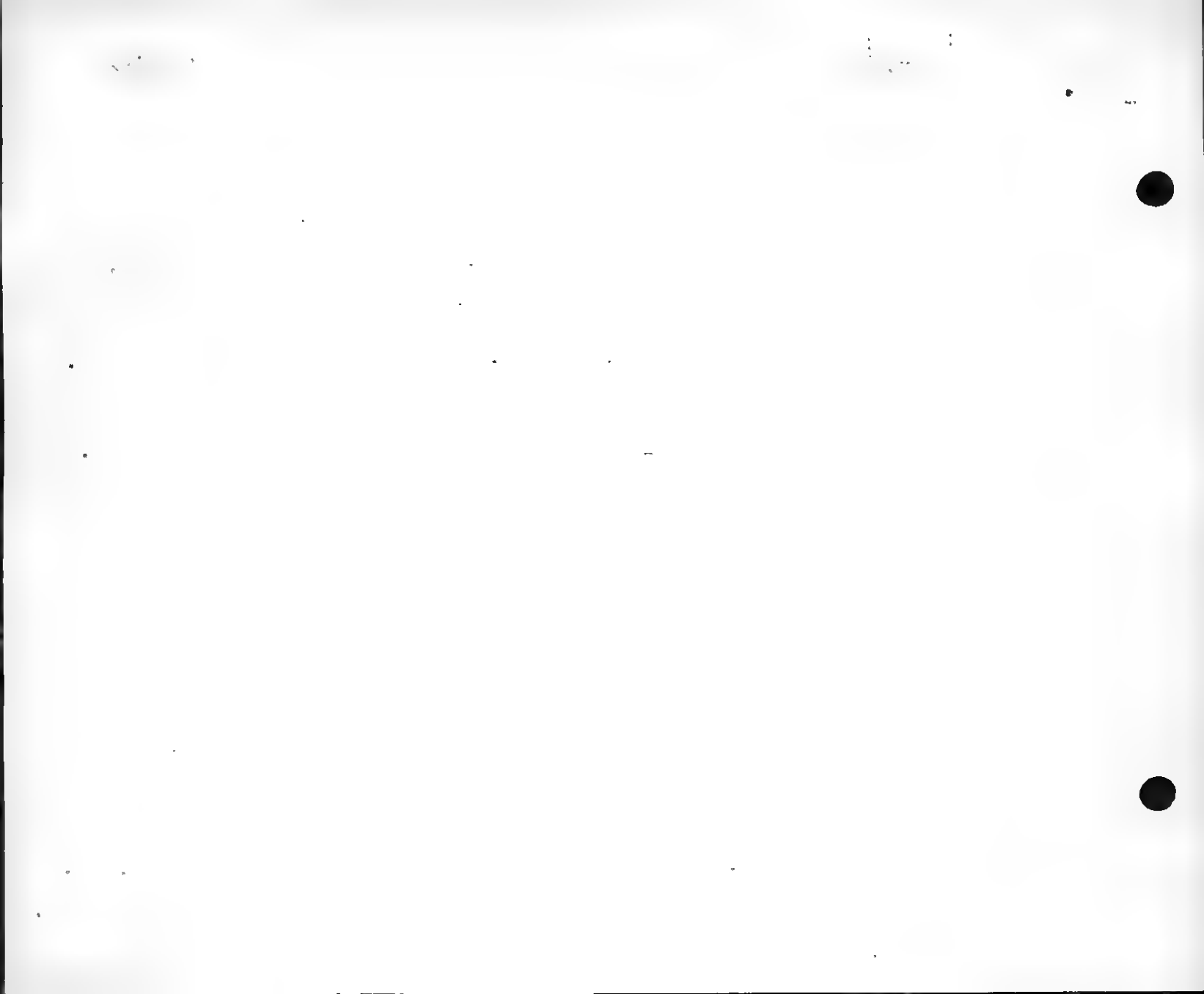
14293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14292

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Julip Lane</u>		d. STREET ADDRESS <u>Julip Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Howard A. Bandy</u>		4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/19/08</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>1</u> Hours <u>1</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Head of Estimating Dept. Printing Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. FATHER'S NAME <u>Emanuel Bandy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. MOTHER'S NAME <u>Lola Wagner</u>		14. MOTHER'S MARRIAGE NAME <u>Same as above</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>578-22-7079</u>	
17. INFORMANT <u>May H. Bandy - wife</u>		Address <u>Same as above</u> Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Cardiovascular Disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (b) <u>Cardiovascular Disease</u> DUE TO (c) <u>Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>10/20/66</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-22-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Montgomery County, Md.</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 24 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



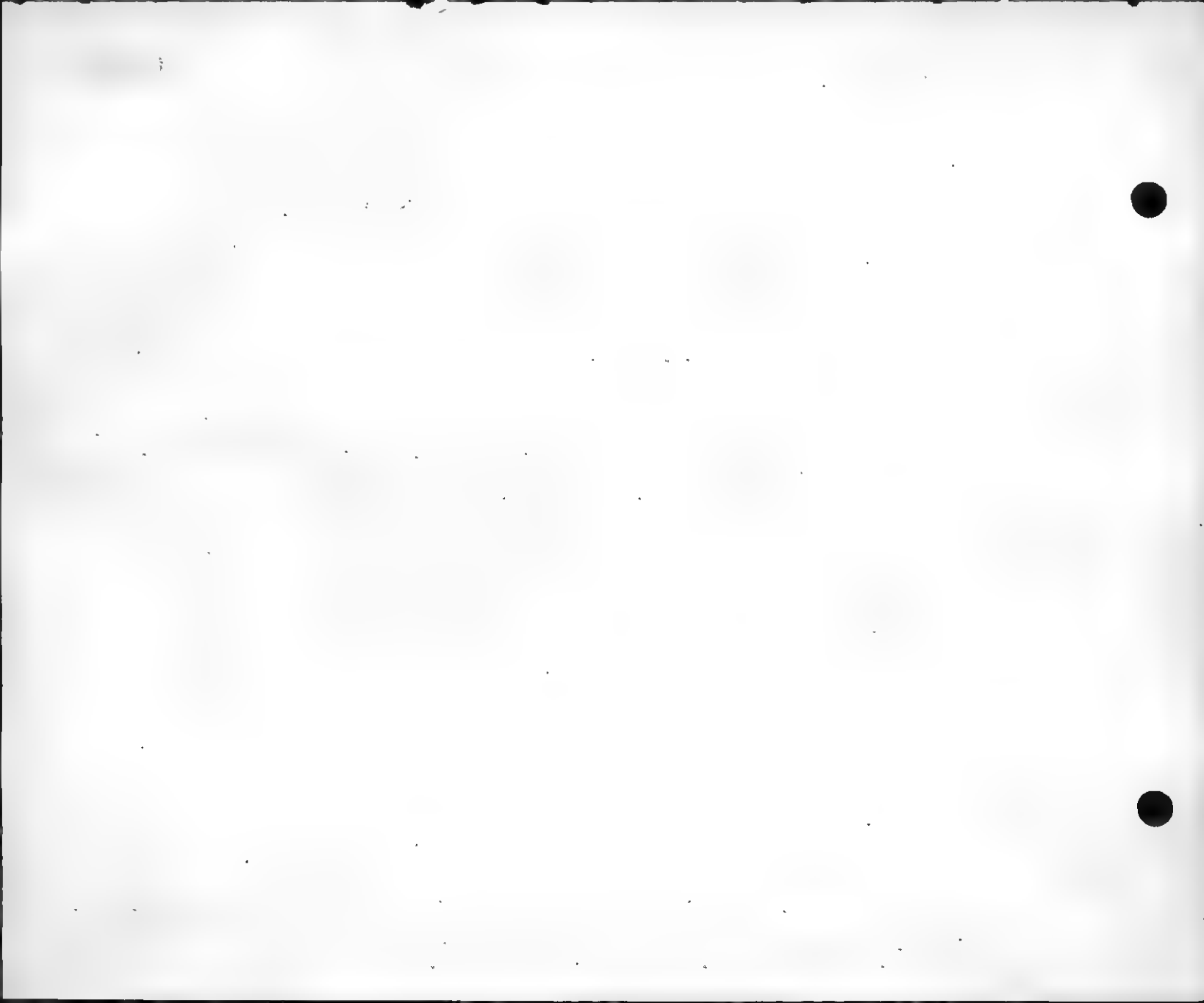


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14294 CERTIFICATE OF DEATH 14293

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> c. LENGTH OF STAY IN 1b <u>1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cedar Haven Rest Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8214 Cedar Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur Jay BARKER</u> First Middle Last 4. DATE OF DEATH <u>Oct. 10 1966</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>4/16/1887</u> 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u> 10b. KING OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New York State</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Barker</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>34-36-3193A</u> 17. INFORMANT <u>Joann B. Comstock</u> Address <u>12406 Downer Dr. Wheaton, Md.</u>		18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u>Old age</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinomatosis from prostate</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>None</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u> 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 26</u> , 19 <u>66</u> , to <u>Oct 10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct. 9</u> , 19 <u>66</u> , and that death occurred at <u>1:25 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Russell C. Bufalino</u> 22c. PHYSICIAN'S NAME (Type) <u>Russell C. Bufalino, M.D.</u>		22b. DATE SIGNED <u>Oct 10, 1966</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Oct. 13, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>		24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> OATE <u>OCT 14 1966</u> 25b. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14295

## CERTIFICATE OF DEATH

14294

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp</u>		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>716 East Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type or print) <u>ELGENE</u> First <u>(NMD)</u> Middle <u>BARNES</u> Last <b>4 DATE OF DEATH</b> Month <u>10</u> Day <u>1</u> Year <u>1966</u>		<b>5 SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>7-8-1896</u> <b>9 AGE</b> (In years last birthday) <u>70</u> yrs <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Guard (Retired)</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Asso. Perpetual Bldg.</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Harry C. Barnes</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Cornelia Marlow</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u> <b>16. SOCIAL SECURITY NO.</b> <u>218-20-1466</u> <b>17. INFORMANT</b> <u>716 Gist Avenue, S.S., Md. Margaret Barnes, wife</u>	
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema of Lungs</u> <u>5211</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Decomposition</u> DUE TO (c) <u>.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8-10 days</u> <u>4-5 yrs</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Arteriosclerosis</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED:</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1946</u> <b>to</b> <u>1 Oct</u> , 19 <u>66</u> , that (I) (we) lost the deceased alive on <u>30 Sept</u> 19 <u>66</u> , and that death occurred at <u>11 A</u> M, from causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>William D. And</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>10/1/66</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>William D. And</u>		<b>22d. ADDRESS</b> <u>9006 Colesville Rd., S.S., Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Oct. 4, 1966</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek Cemetery</u>		<b>23d. LOCATION (City or Town) (County) (State)</b> <u>Washington, D. C.</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Clark E. Wisor</u> <u>8434 Georgia Ave.</u> <u>Warner E. Humphrey, Inc.</u> <u>Silver Spring, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>OCT 5 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

**Abstract**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

(M)

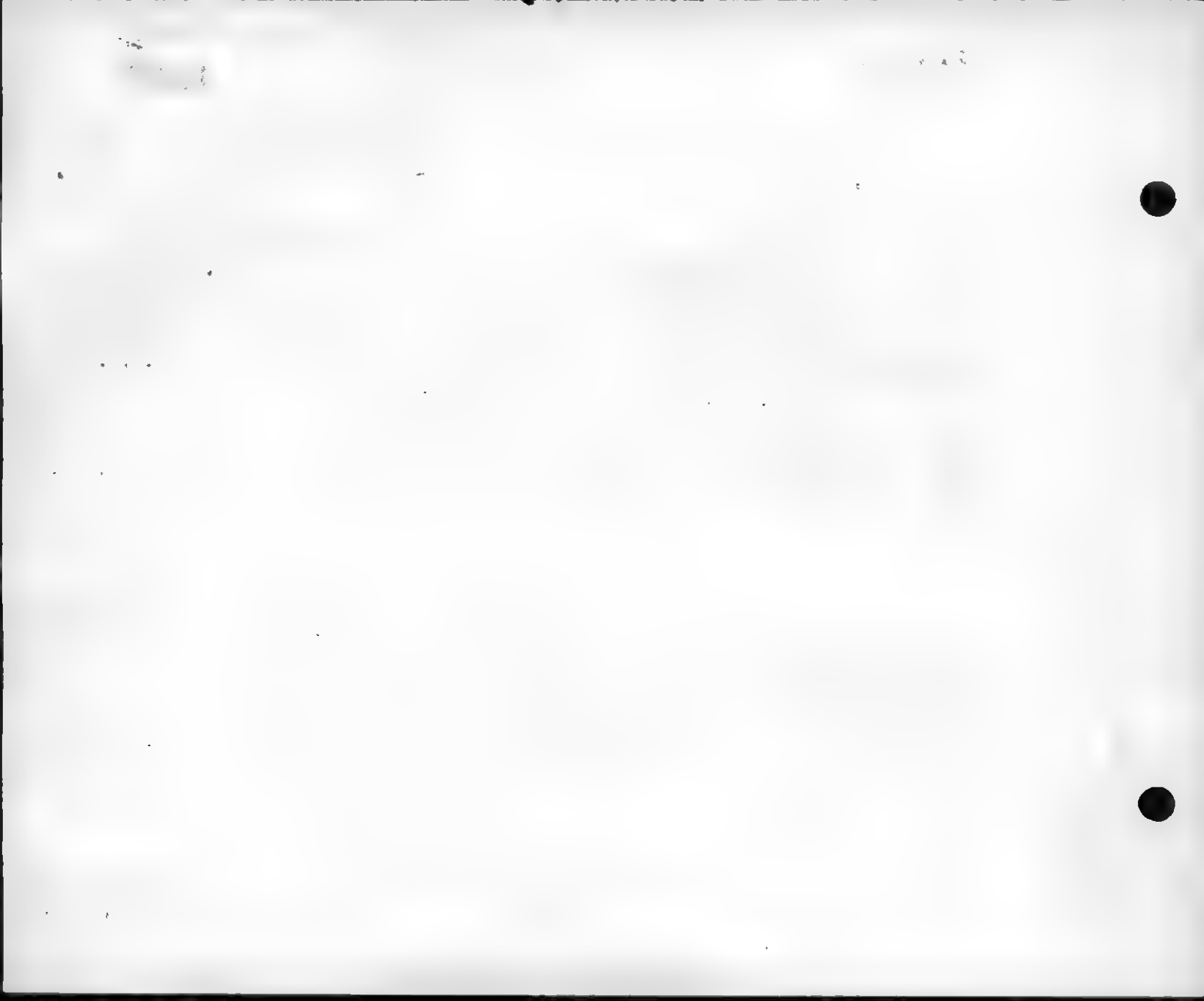
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14296

CERTIFICATE OF DEATH

14295

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA, MARYLAND</b>			c. LENGTH OF STAY IN 1b <b>3 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RESMOR SANITARIUM</b>				d. STREET ADDRESS <b>5534 Johnson Avenue</b>			e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>William Daniel Barnett</b>				4 DATE OF DEATH Month <b>Oct.</b> Day <b>14</b> Year <b>19 66</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 1881</b>		9 AGE (In years last birthday) <b>85 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>John C. Barnett</b>				14. MOTHER'S MAIDEN NAME <b>Arcadia Hall</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <b>Edith Barnett. 5534 Johnson Ave Bethesda, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> <b>1201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1-2 hrs</b> <b>57 yrs</b> <b>10+ yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Goiter, Hypertension, CVA 10+ yrs</b>							19. WAS A TOLPS PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Death</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , to <b>present</b> , that (I) (we) last saw the deceased alive on <b>10/11/66</b> , and that death occurred at <b>11:00</b> M, from causes and on the date stated above							
22a. SIGNATURE <b>Charles Savarese</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles Savarese, M.D.</b>				22d. ADDRESS <b>Rockville, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-17-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville. Montg, Md.</b>	
24. FUNERAL DIRECTOR <b>Ernest C. Gartner</b>				ADDRESS <b>1000 1st St. N.W. Washington, D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 17 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

CERTIFICATE OF DEATH

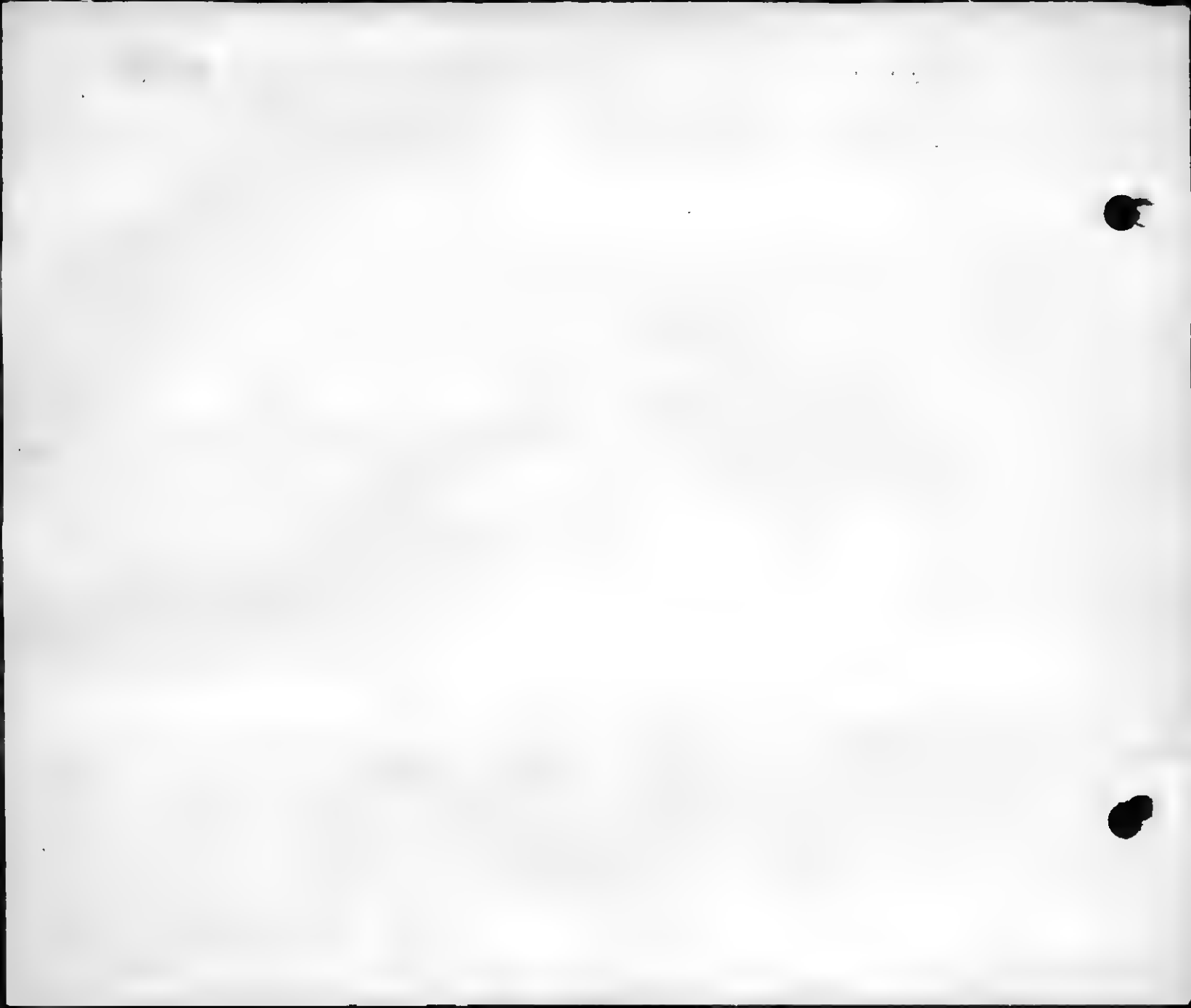
14297

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1gx, 1gy, 1gz, 1ha, 1hb, 1hc, 1hd, 1he, 1hf, 1hg, 1hh, 1hi, 1hj, 1hk, 1hl, 1hm, 1hn, 1ho, 1hp, 1hq, 1hr, 1hs, 1ht, 1hu, 1hv, 1hw, 1hx, 1hy, 1hz, 1ia, 1ib, 1ic, 1id, 1ie, 1if, 1ig, 1ih, 1ii, 1ij, 1ik, 1il, 1im, 1in, 1io, 1ip, 1iq, 1ir, 1is, 1it, 1iu, 1iv, 1iw, 1ix, 1iy, 1iz, 1ja, 1jb, 1jc, 1jd, 1je, 1jf, 1jg, 1jh, 1ji, 1jj, 1jk, 1jl, 1jm, 1jn, 1jo, 1jp, 1jq, 1jr, 1js, 1jt, 1ju, 1jv, 1jw, 1jx, 1jy, 1jz, 1ka, 1kb, 1kc, 1kd, 1ke, 1kf, 1kg, 1kh, 1ki, 1kj, 1kk, 1kl, 1km, 1kn, 1ko, 1kp, 1kq, 1kr, 1ks, 1kt, 1ku, 1kv, 1kw, 1kx, 1ky, 1kz, 1la, 1lb, 1lc, 1ld, 1le, 1lf, 1lg, 1lh, 1li, 1lj, 1lk, 1ll, 1lm, 1ln, 1lo, 1lp, 1lq, 1lr, 1ls, 1lt, 1lu, 1lv, 1lw, 1lx, 1ly, 1lz, 1ma, 1mb, 1mc, 1md, 1me, 1mf, 1mg, 1mh, 1mi, 1mj, 1mk, 1ml, 1mm, 1mn, 1mo, 1mp, 1mq, 1mr, 1ms, 1mt, 1mu, 1mv, 1mw, 1mx, 1my, 1mz, 1na, 1nb, 1nc, 1nd, 1ne, 1nf, 1ng, 1nh, 1ni, 1nj, 1nk, 1nl, 1nm, 1nn, 1no, 1np, 1nq, 1nr, 1ns, 1nt, 1nu, 1nv, 1nw, 1nx, 1ny, 1nz, 1oa, 1ob, 1oc, 1od, 1oe, 1of, 1og, 1oh, 1oi, 1oj, 1ok, 1ol, 1om, 1on, 1oo, 1op, 1oq, 1or, 1os, 1ot, 1ou, 1ov, 1ow, 1ox, 1oy, 1oz, 1pa, 1pb, 1pc, 1pd, 1pe, 1pf, 1pg, 1ph, 1pi, 1pj, 1pk, 1pl, 1pm, 1pn, 1po, 1pp, 1pq, 1pr, 1ps, 1pt, 1pu, 1pv, 1pw, 1px, 1py, 1pz, 1qa, 1qb, 1qc, 1qd, 1qe, 1qf, 1qg, 1qh, 1qi, 1qj, 1qk, 1ql, 1qm, 1qn, 1qo, 1qp, 1qq, 1qr, 1qs, 1qt, 1qu, 1qv, 1qw, 1qx, 1qy, 1qz, 1ra, 1rb, 1rc, 1rd, 1re, 1rf, 1rg, 1rh, 1ri, 1rj, 1rk, 1rl, 1rm, 1rn, 1ro, 1rp, 1rq, 1rr, 1rs, 1rt, 1ru, 1rv, 1rw, 1rx, 1ry, 1rz, 1sa, 1sb, 1sc, 1sd, 1se, 1sf, 1sg, 1sh, 1si, 1sj, 1sk, 1sl, 1sm, 1sn, 1so, 1sp, 1sq, 1sr, 1ss, 1st, 1su, 1sv, 1sw, 1sx, 1sy, 1sz, 1ta, 1tb, 1tc, 1td, 1te, 1tf, 1tg, 1th, 1ti, 1tj, 1tk, 1tl, 1tm, 1tn, 1to, 1tp, 1tq, 1tr, 1ts, 1tt, 1tu, 1tv, 1tw, 1tx, 1ty, 1tz, 1ua, 1ub, 1uc, 1ud, 1ue, 1uf, 1ug, 1uh, 1ui, 1uj, 1uk, 1ul, 1um, 1un, 1uo, 1up, 1uq, 1ur, 1us, 1ut, 1uu, 1uv, 1uw, 1ux, 1uy, 1uz, 1va, 1vb, 1vc, 1vd, 1ve, 1vf, 1vg, 1vh, 1vi, 1vj, 1vk, 1vl, 1vm, 1vn, 1vo, 1vp, 1vq, 1vr, 1vs, 1vt, 1vu, 1vv, 1vw, 1vx, 1vy, 1vz, 1wa, 1wb, 1wc, 1wd, 1we, 1wf, 1wg, 1wh, 1wi, 1wj, 1wk, 1wl, 1wm, 1wn, 1wo, 1wp, 1wq, 1wr, 1ws, 1wt, 1wu, 1wv, 1ww, 1wx, 1wy, 1wz, 1xa, 1xb, 1xc, 1xd, 1xe, 1xf, 1xg, 1xh, 1xi, 1xj, 1xk, 1xl, 1xm, 1xn, 1xo, 1xp, 1xq, 1xr, 1xs, 1xt, 1xu, 1xv, 1xw, 1xx, 1xy, 1xz, 1ya, 1yb, 1yc, 1yd, 1ye, 1yf, 1yg, 1yh, 1yi, 1yj, 1yk, 1yl, 1ym, 1yn, 1yo, 1yp, 1yq, 1yr, 1ys, 1yt, 1yu, 1yv, 1yw, 1yx, 1yy, 1yz, 1za, 1zb, 1zc, 1zd, 1ze, 1zf, 1zg, 1zh, 1zi, 1zj, 1zk, 1zl, 1zm, 1zn, 1zo, 1zp, 1zq, 1zr, 1zs, 1zt, 1zu, 1zv, 1zw, 1zx, 1zy, 1zz, 2aa, 2ab, 2ac, 2ad, 2ae, 2af, 2ag, 2ah, 2ai, 2aj, 2ak, 2al, 2am, 2an, 2ao, 2ap, 2aq, 2ar, 2as, 2at, 2au, 2av, 2aw, 2ax, 2ay, 2az, 2ba, 2bb, 2bc, 2bd, 2be, 2bf, 2bg, 2bh, 2bi, 2bj, 2bk, 2bl, 2bm, 2bn, 2bo, 2bp, 2bq, 2br, 2bs, 2bt, 2bu, 2bv, 2bw, 2bx, 2by, 2bz, 2ca, 2cb, 2cc, 2cd, 2ce, 2cf, 2cg, 2ch, 2ci, 2cj, 2ck, 2cl, 2cm, 2cn, 2co, 2cp, 2cq, 2cr, 2cs, 2ct, 2cu, 2cv, 2cw, 2cx, 2cy, 2cz, 2da, 2db, 2dc, 2dd, 2de, 2df, 2dg, 2dh, 2di, 2dj, 2dk, 2dl, 2dm, 2dn, 2do, 2dp, 2dq, 2dr, 2ds, 2dt, 2du, 2dv, 2dw, 2dx, 2dy, 2dz, 2ea, 2eb, 2ec, 2ed, 2ee, 2ef, 2eg, 2eh, 2ei, 2ej, 2ek, 2el, 2em, 2en, 2eo, 2ep, 2eq, 2er, 2es, 2et, 2eu, 2ev, 2ew, 2ex, 2ey, 2ez, 2fa, 2fb, 2fc, 2fd, 2fe, 2ff, 2fg, 2fh, 2fi, 2fj, 2fk, 2fl, 2fm, 2fn, 2fo, 2fp, 2fq, 2fr, 2fs, 2ft, 2fu, 2fv, 2fw, 2fx, 2fy, 2fz, 2ga, 2gb, 2gc, 2gd, 2ge, 2gf, 2gg, 2gh, 2gi, 2gj, 2gk, 2gl, 2gm, 2gn, 2go, 2gp, 2gq, 2gr, 2gs, 2gt, 2gu, 2gv, 2gw, 2gx, 2gy, 2gz, 2ha, 2hb, 2hc, 2hd, 2he, 2hf, 2hg, 2hh, 2hi, 2hj, 2hk, 2hl, 2hm, 2hn, 2ho, 2hp, 2hq, 2hr, 2hs, 2ht, 2hu, 2hv, 2hw, 2hx, 2hy, 2hz, 2ia, 2ib, 2ic, 2id, 2ie, 2if, 2ig, 2ih, 2ii, 2ij, 2ik, 2il, 2im, 2in, 2io, 2ip, 2iq, 2ir, 2is, 2it, 2iu, 2iv, 2iw, 2ix, 2iy, 2iz, 2ja, 2jb, 2jc, 2jd, 2je, 2jf, 2jg, 2jh, 2ji, 2jj, 2jk, 2jl, 2jm, 2jn, 2jo, 2jp, 2jq, 2jr, 2js, 2jt, 2ju, 2jv, 2jw, 2jx, 2jy, 2jz, 2ka, 2kb, 2kc, 2kd, 2ke, 2kf, 2kg, 2kh, 2ki, 2kj, 2kk, 2kl, 2km, 2kn, 2ko, 2kp, 2kq, 2kr, 2ks, 2kt, 2ku, 2kv, 2kw, 2kx, 2ky, 2kz, 2la, 2lb, 2lc, 2ld, 2le, 2lf, 2lg, 2lh, 2li, 2lj, 2lk, 2ll, 2lm, 2ln, 2lo, 2lp, 2lq, 2lr, 2ls, 2lt, 2lu, 2lv, 2lw, 2lx, 2ly, 2lz, 2ma, 2mb, 2mc, 2md, 2me, 2mf, 2mg, 2mh, 2mi, 2mj, 2mk, 2ml, 2mm, 2mn, 2mo, 2mp, 2mq, 2mr, 2ms, 2mt, 2mu, 2mv, 2mw, 2mx, 2my, 2mz, 2na, 2nb, 2nc, 2nd, 2ne, 2nf, 2ng, 2nh, 2ni, 2nj, 2nk, 2nl, 2nm, 2nn, 2no, 2np, 2nq, 2nr, 2ns, 2nt, 2nu, 2nv, 2nw, 2nx, 2ny, 2nz, 2oa, 2ob, 2oc, 2od, 2oe, 2of, 2og, 2oh, 2oi, 2oj, 2ok, 2ol, 2om, 2on, 2oo, 2op, 2oq, 2or, 2os, 2ot, 2ou, 2ov, 2ow, 2ox, 2oy, 2oz, 2pa, 2pb, 2pc, 2pd, 2pe, 2pf, 2pg, 2ph, 2pi, 2pj, 2pk, 2pl, 2pm, 2pn, 2po, 2pp, 2pq, 2pr, 2ps, 2pt, 2pu, 2pv, 2pw, 2px, 2py, 2pz, 2qa, 2qb, 2qc, 2qd, 2qe, 2qf, 2qg, 2qh, 2qi, 2qj, 2qk, 2ql, 2qm, 2qn, 2qo, 2qp, 2qq, 2qr, 2qs, 2qt, 2qu, 2qv, 2qw, 2qx, 2qy, 2qz, 2ra, 2rb, 2rc, 2rd, 2re, 2rf, 2rg, 2rh, 2ri, 2rj, 2rk, 2rl, 2rm, 2rn, 2ro, 2rp, 2rq, 2rr, 2rs, 2rt, 2ru, 2rv, 2rw, 2rx, 2ry, 2rz, 2sa, 2sb, 2sc, 2sd, 2se, 2sf, 2sg, 2sh, 2si, 2sj, 2sk, 2sl, 2sm, 2sn, 2so, 2sp, 2sq, 2sr, 2ss, 2st, 2su, 2sv, 2sw, 2sx, 2sy, 2sz, 2ta, 2tb, 2tc, 2td, 2te, 2tf, 2tg, 2th, 2ti, 2tj, 2tk, 2tl, 2tm, 2tn, 2to, 2tp, 2tq, 2tr, 2ts, 2tt, 2tu, 2tv, 2tw, 2tx, 2ty, 2tz, 2ua, 2ub, 2uc, 2ud, 2ue, 2uf, 2ug, 2uh, 2ui, 2uj, 2uk, 2ul, 2um, 2un, 2uo, 2up, 2uq, 2ur, 2us, 2ut, 2uu, 2uv, 2uw, 2ux, 2uy, 2uz, 2va, 2vb, 2vc, 2vd, 2ve, 2vf, 2vg, 2vh, 2vi, 2vj, 2vk, 2vl, 2vm, 2vn, 2vo, 2vp, 2vq, 2vr, 2vs, 2vt, 2vu, 2vv, 2vw, 2vx, 2vy, 2vz, 2wa, 2wb, 2wc, 2wd, 2we, 2wf, 2wg, 2wh, 2wi, 2wj, 2wk, 2wl, 2wm, 2wn, 2wo, 2wp, 2wq, 2wr, 2ws, 2wt, 2wu, 2wv, 2ww, 2wx, 2wy, 2wz, 2xa, 2xb, 2xc, 2xd, 2xe, 2xf, 2xg, 2xh, 2xi, 2xj, 2xk, 2xl, 2xm, 2xn, 2xo, 2xp, 2xq, 2xr, 2xs, 2xt, 2xu, 2xv, 2xw, 2xx, 2xy, 2xz, 2ya, 2yb, 2yc, 2yd, 2ye, 2yf, 2yg, 2yh, 2yi, 2yj, 2yk, 2yl, 2ym, 2yn, 2yo, 2yp, 2yq, 2yr, 2ys, 2yt, 2yu, 2yv, 2yw, 2yx, 2yy, 2yz, 2za, 2zb, 2zc, 2zd, 2ze, 2zf, 2zg, 2zh, 2zi, 2zj, 2zk, 2zl, 2zm, 2zn, 2zo, 2zp, 2zq, 2zr, 2zs, 2zt, 2zu, 2zv, 2zw, 2zx, 2zy, 2zz

14296

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Rockville</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Grosvenor Park Apts. 10500 Rockville Pike, Apt. 1311</i>		d. STREET ADDRESS <i>10500 Rockville Pike</i>	
3. NAME OF DECEASED (Type or print) <i>ROBERT J. BARRETT</i>		4. DATE OF DEATH <i>10 29 1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 20<sup>th</sup> 1902</i>
9. AGE (In years last birthday) <i>64</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Det. Md. Police Dept</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Washington</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William J. Barrett</i>		14. MOTHER'S MAIDEN NAME <i>Susan C. Barry</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service))		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Michael Barrett</i>		Address <i>10500 Rockville Pike</i>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>332 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Encephalomalacia</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>3 years</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive cardiovascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7 Oct 1966</i> to <i>29 Oct 1966</i> that (I) (we) last saw the deceased alive on <i>28 Oct 1966</i> and that death occurred at <i>6:20 PM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Erich D. Ryll M.D.</i> M.D.		22b. DATE SIGNED <i>29 Oct 66</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>4602 Rosedale Bethesda Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>11-3-66</i>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <i>State of St. Louis</i>		23d. LOCATION (City, town, or county) (State) <i>Rockville Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas B. Huxford</i>		ADDRESS <i>4948 Olive Ave NW</i>	
25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	
DATE <i>NOV 3 1966</i>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14298

## CERTIFICATE OF DEATH

14297

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St Marys</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY in 1b <u>9das</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtwn</u> <u>18 2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				d. STREET ADDRESS <u>Brento Apartments</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>May</u> Last <u>Barsosky</u>				4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>19 66</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7 February 1944</u>		9. AGE (In years last birthday) <u>22</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Tokos</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kinny</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>John Barsosky Brento Apts Leonardtown Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Irreversible Shock</u> <u>7545</u> DUE TO (b) <u>Open Heart Surgery</u> DUE TO (c) <u>Congenital Heart Disease - Pulmonary Stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(it)</del> (this hospital) attended the deceased from <u>26 Sept</u> , 19 <u>66</u> , to <u>5 Oct</u> , 19 <u>66</u> , that <del>(it)</del> (we) last saw the deceased alive on <u>5 Oct</u> , 19 <u>66</u> , and that death occurred at <u>9:10 PM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>D. H. Gaylor</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6 Oct 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. H. GAYLOR, COR, MC, USN</u>						22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 10, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u>			23d. LOCATION (City or Town) (County) (State) <u>Binghamton NY</u>		
24. FUNERAL DIRECTOR <u>Joseph Gawler, 5130 Wisconsin Ave, Wash. D.C.</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2001

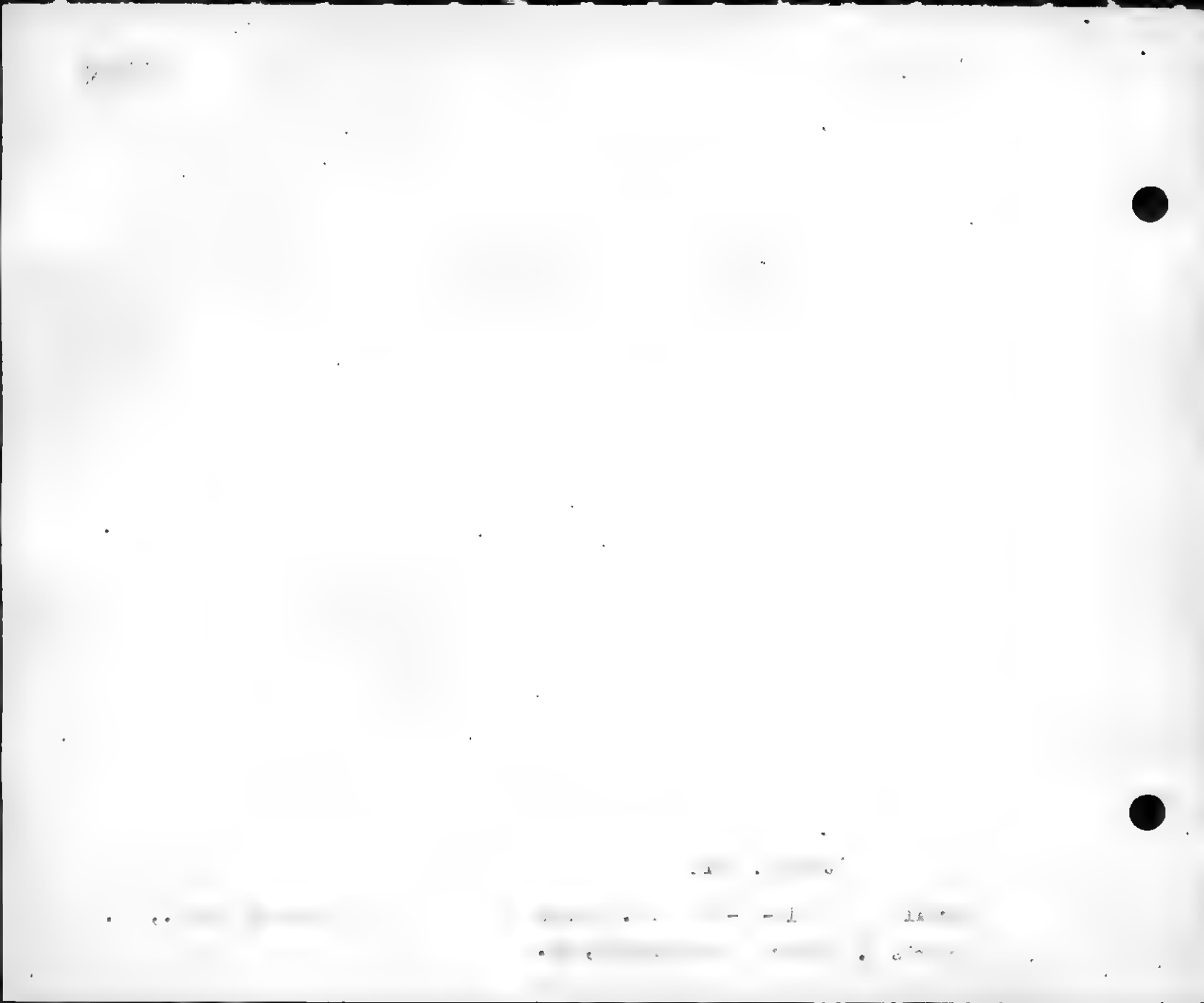


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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14299 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14298

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Giney</u> c. LENGTH OF STAY IN 1b <u>72 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mont. Gen. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Unity</u> d. STREET ADDRESS <u>Rt. #1 Brookeville</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FANNIE C. BEALL</u> First Middle Last		4. DATE OF DEATH <u>Oct. 15 1966</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1877</u> 9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Illinois</u>
13. FATHER'S NAME <u>Jeremiah Cantrall</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		14. MOTHER'S MAIDEN NAME <u>Henriella Downs</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Edna Charlton</u> Address <u>Same as 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia -</u> 4040 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of Rib -</u> DUE TO underlying cause (c) <u>Generalized Arterio Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>72 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell at home causing Fracture of Hip.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>8-3 1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Unity. Mont. Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>John G. Ball</u>		22. DATE SIGNED <u>10/15/66</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-18-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>	23d. LOCATION (City, town or county) (State) <u>Sunshine Mont., Md.</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

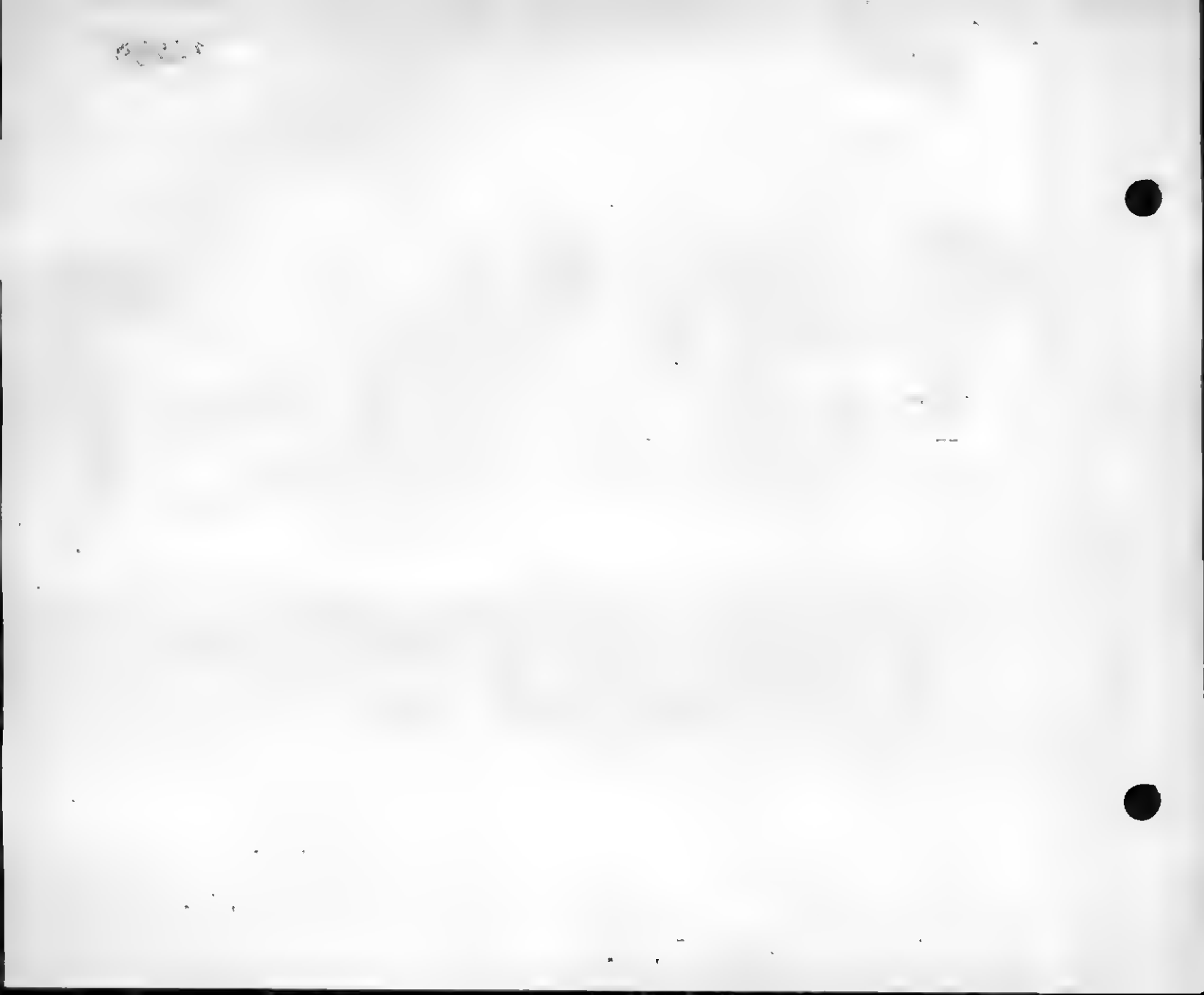
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14300

CERTIFICATE OF DEATH

14299

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Timothy</u> Middle <u>ALAN</u> Last <u>Beall</u>				4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1966</u>			
5. SEX <u>m.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-14-66</u>	
9. AGE (In years last birthday) yrs. <u>1</u> Months <u>2</u> Days <u>2</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Tech.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRONICS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>John P. Beall</u>			
14. MOTHER'S MAIDEN NAME <u>BARBARA A. Lumsden</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes give war or dates of service) <u>--</u>			
16. SOCIAL SECURITY NO. <u>--</u>				17. INFORMANT Address <u>Mother AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTERAURAL HEMORRHAGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>THIS</u> DUE TO (c) <u>THIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>14 OCT</u> , 19 <u>66</u> , to <u>15 OCT</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>15 OCT</u> , 19 <u>66</u> , and that death occurred at <u>15 OCT</u> , 19 <u>66</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Gary Brecken</u>				22b. DATE SIGNED <u>15 OCT. 66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Gary Brecken</u>				22d. ADDRESS <u>Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>10/17/66</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>				23d. LOCATION (City, town or county) (State) <u>Rockville, Md.</u>			
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>OCT 18 1966</u>			





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

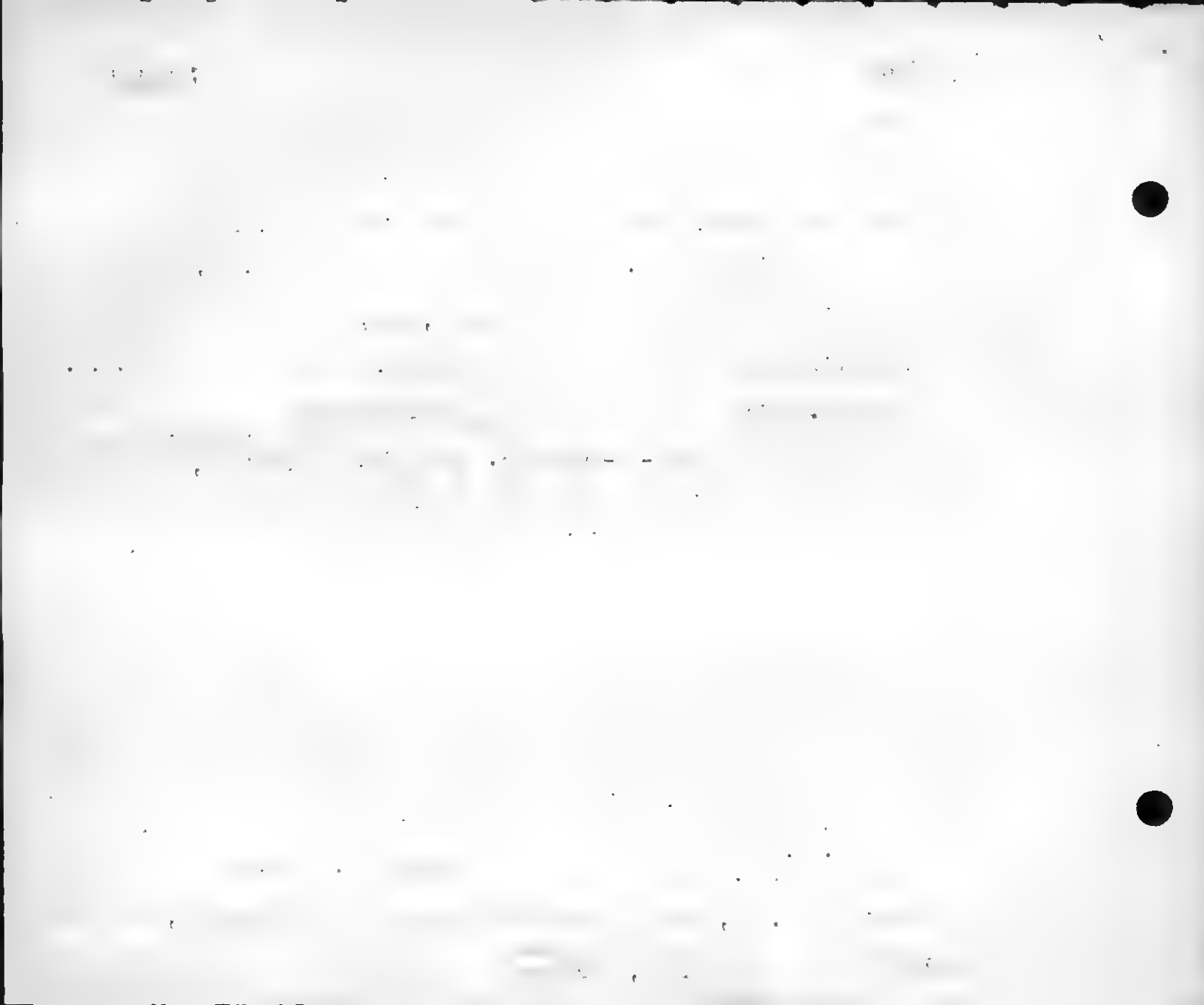
14301

CERTIFICATE OF DEATH

14300

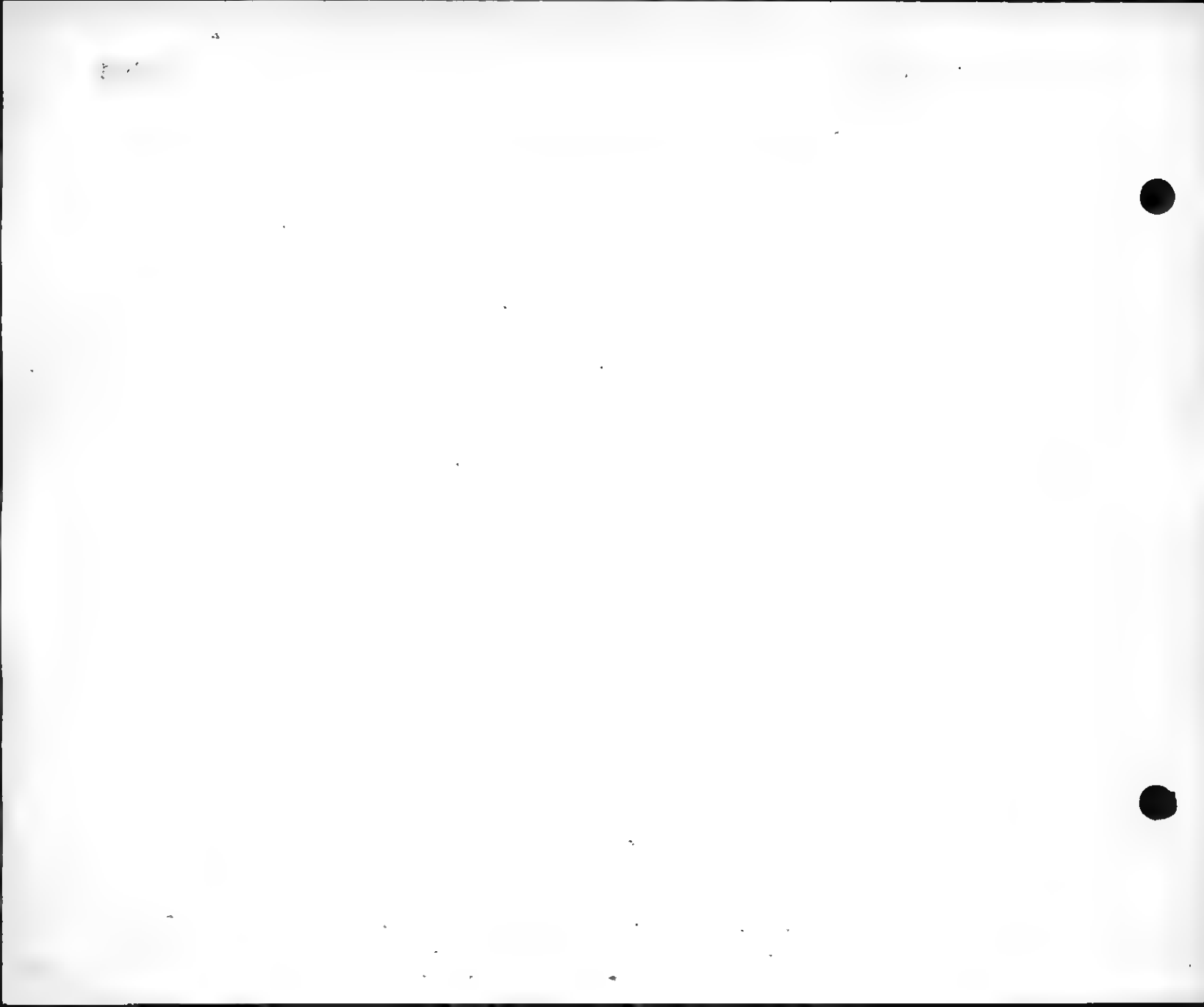
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>814 Viers Mill Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Potomac Valley Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LUCY M. BELT</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>13</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1887</b>	9. AGE (In years last birthday) <b>79 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward L. Heim</b>		14. MOTHER'S MAIDEN NAME <b>Malinda Kemp</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-10-5099B</b>		17. INFORMANT <b>Wm. Stacy Belt</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolus</b> DUE TO <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>10 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1966</b> to <b>13 Oct 1966</b> , that (we) last saw the deceased alive on <b>12 Oct 1966</b> , and that death occurred at <b>2:15 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>W. S. Murphy</b>		22b. DATE SIGNED <b>10/13/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. S. Murphy</b> <b>for Wm. G. Hall</b>		22d. ADDRESS <b>Rockville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 15, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Gaithersburg, Maryland</b>					
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b>		25a. REC'D BY REGISTRAR <b>OCT 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15ME (5)  
6M 1/66

14302		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		14301	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY (In days) <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San &amp; Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1810 Belvedere Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Harold Milton Bennett</u> First Middle Last 4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1966</u>			5. SEX <u>male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 6-19</u> 9. AGE (In years, last birthday) yrs <u>47</u> IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waiter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u> 11. BIRTHPLACE (State or foreign country) <u>Clarksburg Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Joseph A. Bennett</u> 14. MOTHER'S MAIDEN NAME <u>Minnie Becraft</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>WW II</u> 16. SOC. SEC. SECURITY NO. <u>Yes</u> 17. INFORMANT <u>Joan U. Adkins</u> Address <u>4309 Ivy Glenn Road Wheaton, Maryland</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty metamorphosis of liver; moderately</u> DUE TO (b) <u>severe</u> DUE TO (c) <u>Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I(a) if term 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Belden R. Reap</u> EXAMINER'S NAME (Type) <u>Belden R. Reap</u>		M.D. <u>11502 Grandview Ave. Wheaton, Maryland</u> DEPUTY MEDICAL EXAMINER <u>Charles Carter</u> Address (Home, city, town, or county) <u>  </u>		22. DATE SIGNED <u>Oct. 20, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 24, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	
23d. LOCATION (City or town) <u>Arlington, Virginia</u>		23e. (County) <u>  </u>		23f. (State) <u>  </u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. RECEIVED BY REGISTRAR <u>OCT 25 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. (City or town) <u>  </u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

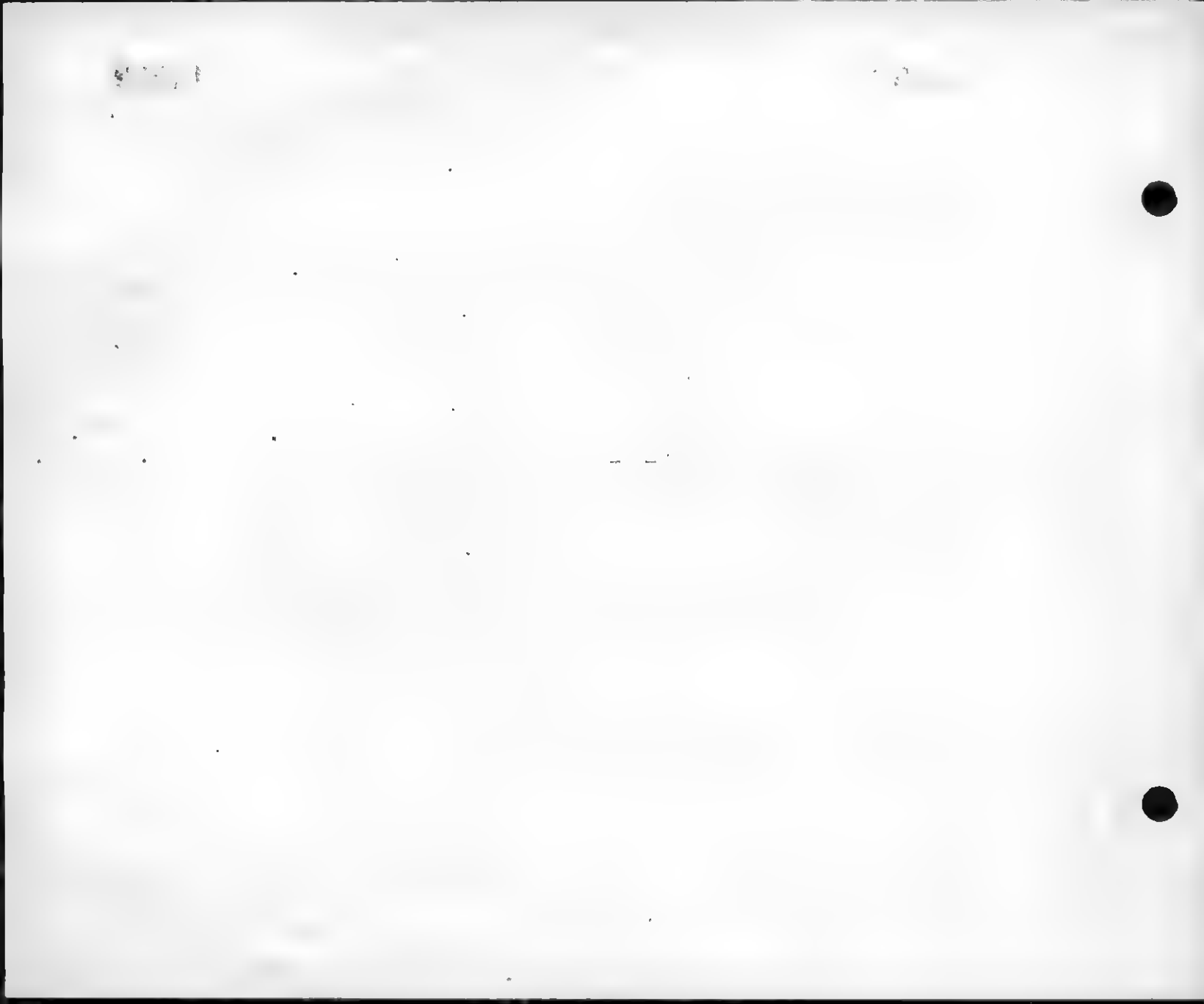
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14303

CERTIFICATE OF DEATH

14302

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision) <input checked="" type="checkbox"/> o. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>32 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>		d. STREET ADDRESS <u>1710 C Commonwealth Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Brund Giordano Benvenuti</u>		4. DATE OF DEATH Month Day Year <u>Oct 4 1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-16-09</u>
9. AGE (In years lost birthday) <u>57</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Woodward + Lothrop</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12 CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Dominic Benvenuti</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Salatore</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>577-48-0945</u>	
17 INFORMANT <u>Janina Benvenuti</u>		1710 C. Address <u>Alex. Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branchiopneumonia</u> 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obstruction, Bacterial infection</u> DUE TO (c) <u>Bronchogenic carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>Month</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/3</u> , 19 <u>66</u> , to <u>10/4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> , 19 <u>66</u> , and that death occurred at <u>11:59</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Eleenuth Crige</u> M.D.		22b. DATE SIGNED <u>Oct 7 1966</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>10-7-66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		23d LOCATION (City or Town) (County) (State) <u>Alexandria, Va</u>	
24. FUNERAL DIRECTOR <u>John C. Everly</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>OCT 7 1966</u>	



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

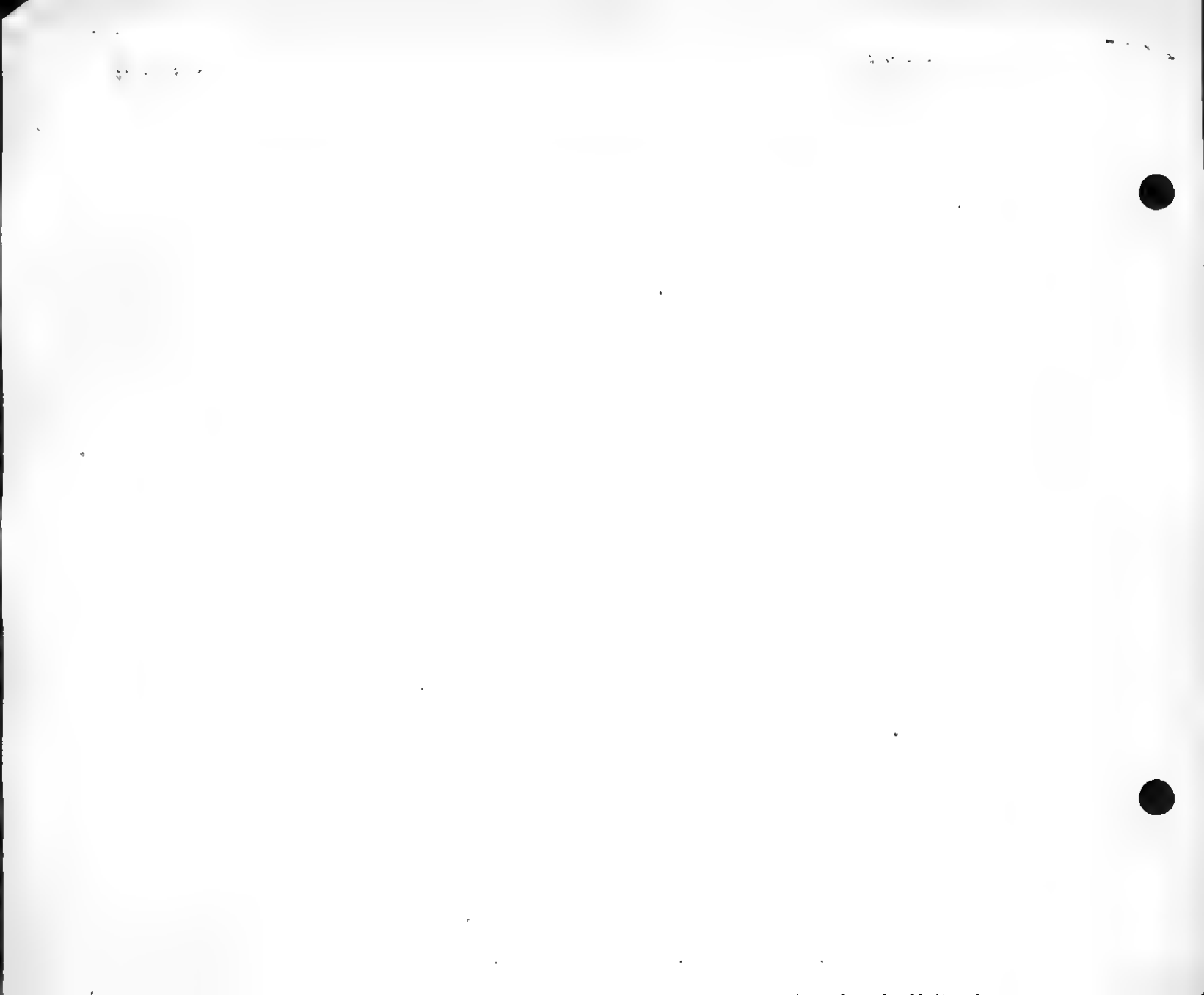
14304

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14303

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b <u>Dea @ 10:57pm</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>9014 Chippendale Circle Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>ALAN Stephen BERKMAN</u>				4 DATE OF DEATH Month <u>Oct</u> Day <u>7</u> Year <u>1966</u>			
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-15-34</u>	9 AGE (In years last birthday) <u>32</u> yrs	10 IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u> Hours <u>15</u> Min <u>00</u>		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physicist</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Gov. Research</u>		11 BIRTHPLACE (State or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Murray Berkman</u>				14 MOTHER'S MAIDEN NAME <u>Mariam Smith</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOC. A. SECURITY NO. <u>Unknown</u>		17 INFORMANT <u>Father</u> Address <u>Same as Item 2.</u> <u>Murray Berkman</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Injuries, multiple (attributed to automobile)</u> + DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Ran down bank onto highway into path of Auto.</u>					
20c TIME OF INJURY Month, Day, Year <u>10:58 pm 10 7 1966</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Highway</u>	20f (City or town) <u>Bethesda</u>	(County) <u>Mont.</u>	(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John M. Ball</u> EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> - <u>10/8/66</u> Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>10/9/66</u>		23c NAME OF CEMETERY OR CREMATORY <u>Wellwood Cem.</u>		23d LOCATION (City or Town) <u>Pinelawn, New York</u> (County) (State)	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Md.</u> ADDRESS				25a REC'D BY REGISTRAR <u>OCT 11 1966</u> DATE			
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

22. DATE SIGNED





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

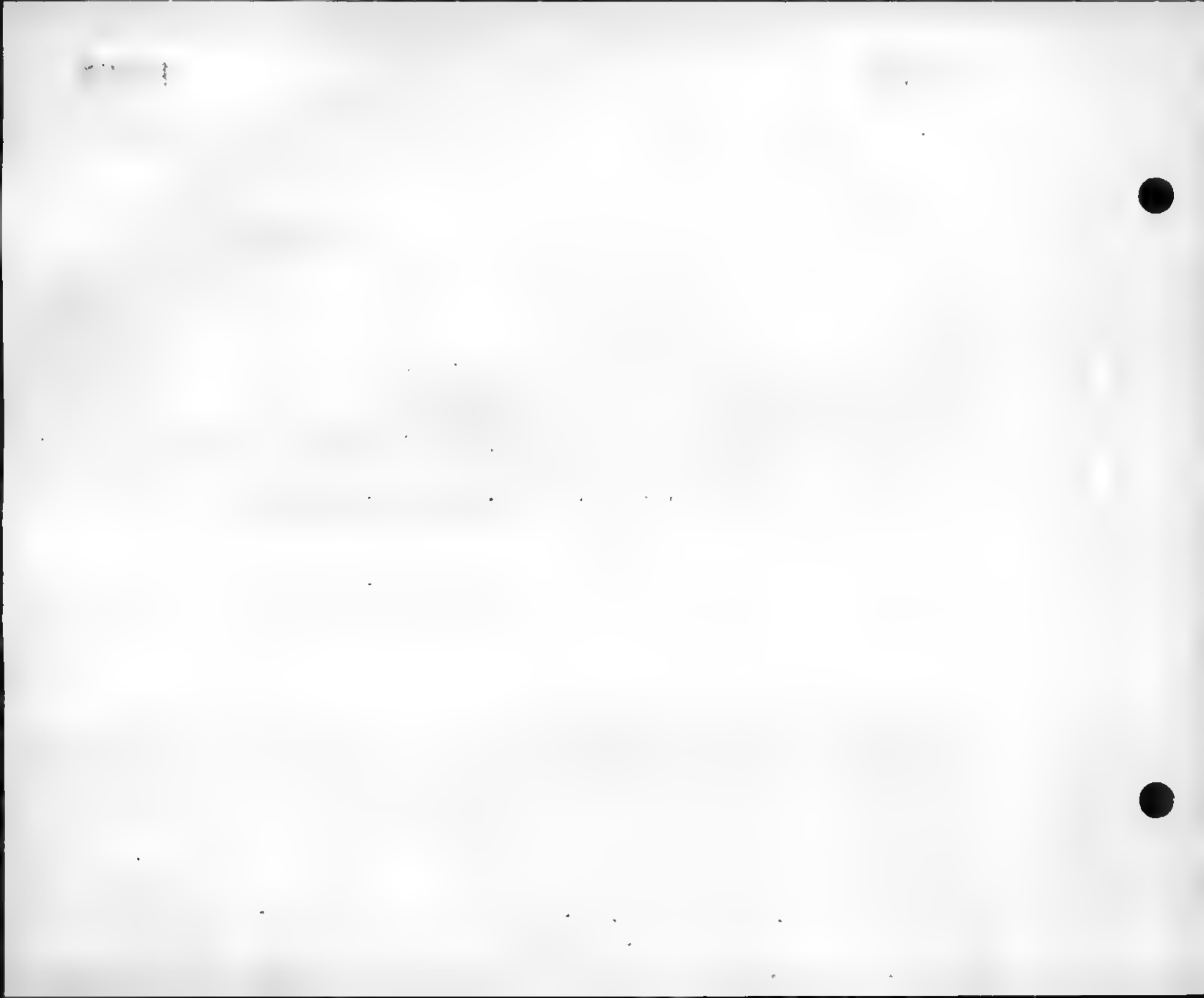
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14305

CERTIFICATE OF DEATH

14304

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>8001 EASTERN AVE.</u>	
3 NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>F</u> Last <u>BIANCHINI</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>23</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 7, 1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sexton</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church Maintenance</u>	11. BIRTHPLACE (County & State, or foreign country) <u>BIGLOTTA, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Joseph Bianchini</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>186-26-6428</u>		17. INFORMANT <u>Mrs. Anna Catino</u> <u>8001 Eastern Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage, right parietal</u> DUE TO (b) <u>lobe</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>64</u> to <u>10-23</u> , 19 <u>66</u> , that (I) <u>met</u> last saw the deceased alive on <u>OCT 23rd</u> 19 <u>66</u> , and that death occurred at <u>8:00 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert Kramer</u>		22b. DATE SIGNED <u>10-23-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT KRAMER</u>		22d. ADDRESS <u>8484 16th ST. SS Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 26, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Mt. Carmel, Pennsylvania</u>
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u> <u>Clark E. Wisor</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 25 1966</u>	



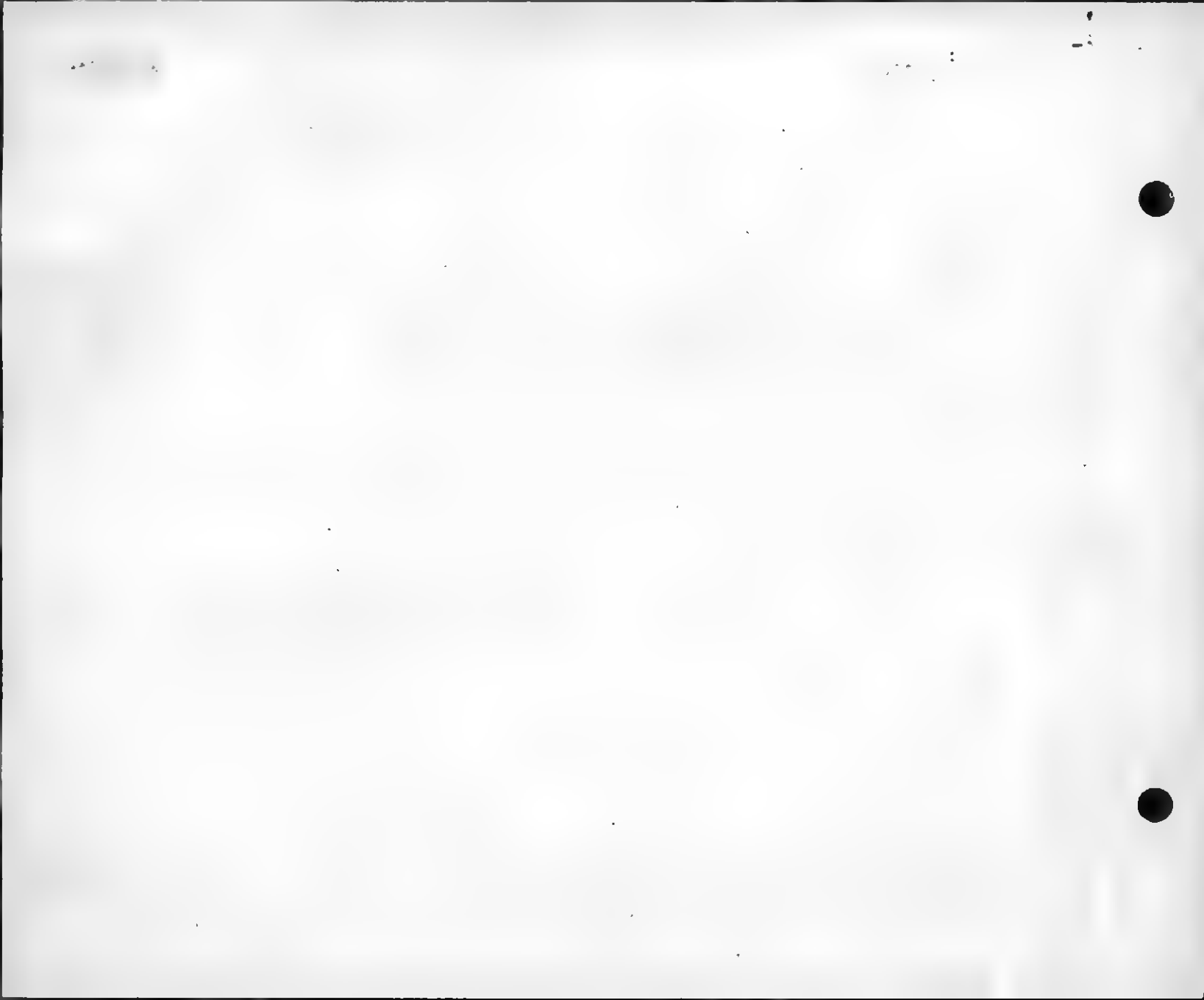
14306

CERTIFICATE OF DEATH

14305

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
c. LENGTH OF STAY IN 1b <u>25 days</u>		d. STREET ADDRESS <u>9909 EMBLE MERE DR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LEA NORA</u> First <u>M</u> Middle <u>Bicicocchi</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/26</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Louis Lanuti</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Lupini</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Husand</u> Address <u>Mario E. Bicicocchi</u> Same as Item 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO (b) <u>CEREBRAL METASTASES</u> DUE TO (c) <u>CARCINOMA OF BREAST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>13 MIN</u> <u>1 YR</u> <u>3 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 15, 1966</u> , to <u>Oct 27, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 26, 1966</u> , and that death occurred at <u>12:20 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. O'Connor</u>		22b. DATE SIGNED <u>OCT 27, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. O'CONNOR MD</u>		22d. ADDRESS <u>8218 WISCONSIN AVE, BETHESDA, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-31-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>V 1</u> 1966	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

14307

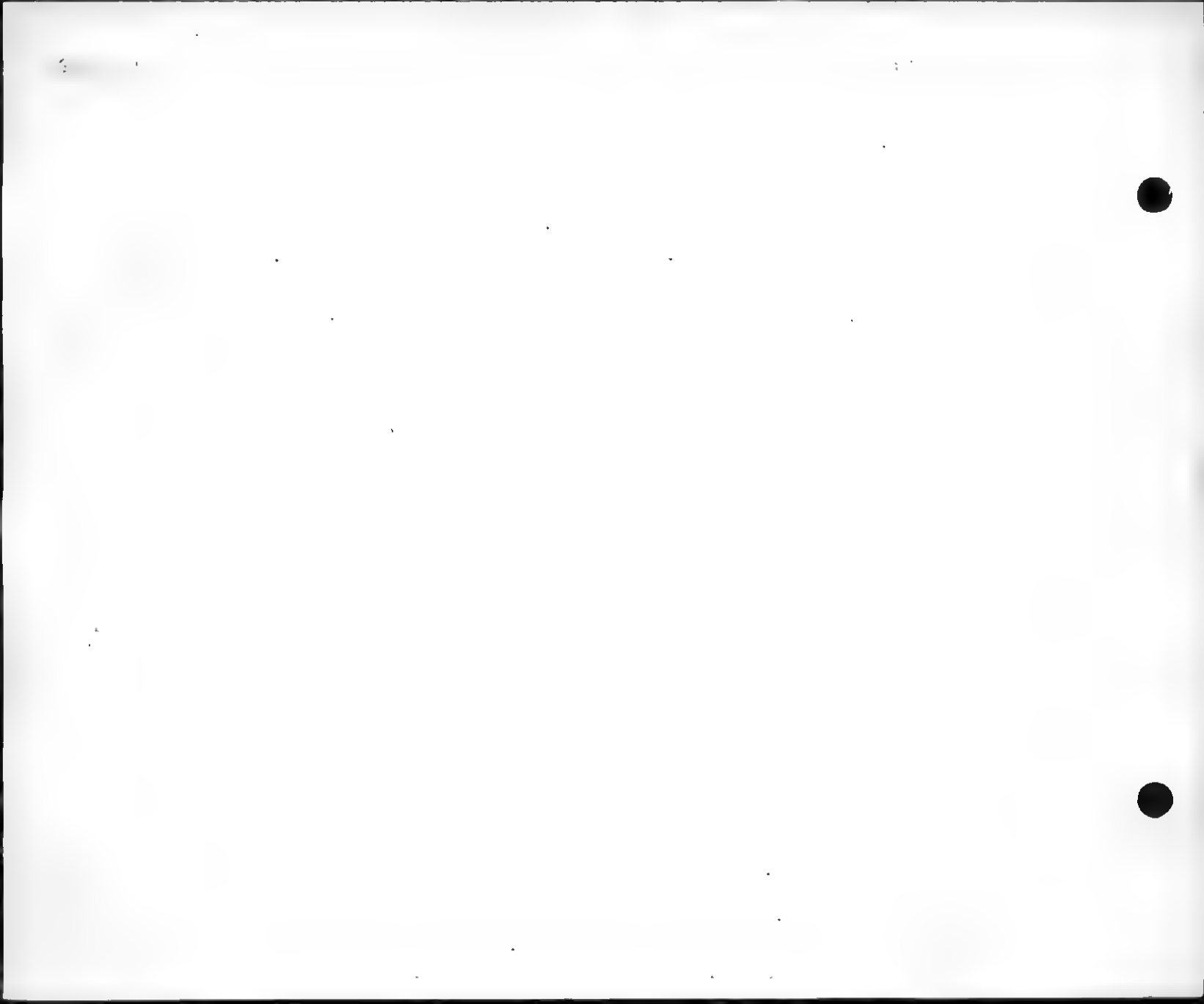
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14306

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				d STREET ADDRESS <u>306 Stonington Road</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Hallie Blanche Blalock</u>				4 DATE OF DEATH Month Day Year <u>October 10 1966</u>			
5 SEX <u>female</u>		6 COLOR OR RACE <u>white</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH <u>December 22, 1898</u>	
9 AGE (In years last birthday) <u>67</u> yrs		F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed Housewife</u>				10b KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11 BIRTHPLACE (State or foreign country) <u>Granville County, N.C.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13 FATHER'S NAME <u>James S. Jones</u>			
14 MOTHER'S M maiden name <u>Pattie Cozart</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>			
16 SOCIAL SECURITY NO <u>246-38-5387</u>				17 INFORMANT <u>Son-James E. Blalock - S.S. Md.</u>			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute intestinal obstruction due to</u> <u>561.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>strangulated right femoral hernia</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month Day Year Hour am p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg etc)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. EXAMINER'S NAME (Type) <u>Belden R. Reap, Wheaton, Md.</u>				22. DATE SIGNED <u>Oct. 11, 1966</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Oct. 13, 1966</u>		23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24 FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>				25a REC'D BY REGISTRAR <u>OCT 14 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

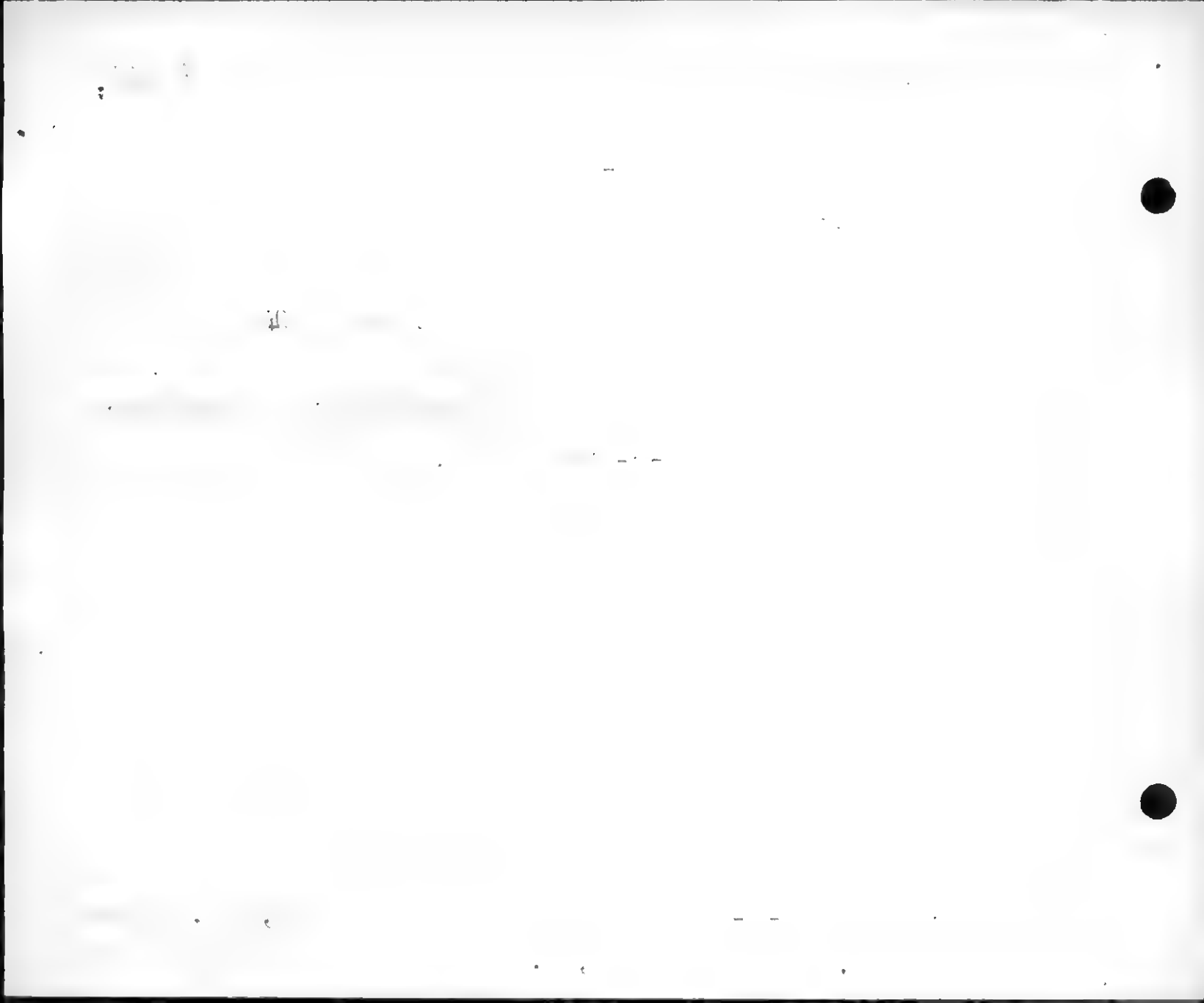
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14308

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14307

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. LENGTH OF STAY IN 1b <u>DOA</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital (DOA)</u>			d. STREET ADDRESS <u>Box 176, RFD #1</u>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Edward Waters Blunt</u>			4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1966</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10/23/09 01</u>		9. AGE (In years last birthday) yrs <u>64</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>American Sales Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Samuel Blunt</u>			14. MOTHER'S MAIDEN NAME <u>Emanda Waters</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>216-24-0012</u>		17. INFORMANT Address <u>son-in-law</u> <u>John A. McGrath, 18820 N.H.Ave. Ashton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per part (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Artery Heart Disease.</u> (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, had an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>OCT. 23, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-25-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Goshen</u>	
23d. LOCATION (City or Town) <u>Goshen, Mont. Maryland</u>		(County)		(State)	
24. FUNERAL DIRECTOR <u>Francis H. Barber Laytonsville, Md.</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>OCT 25 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14309

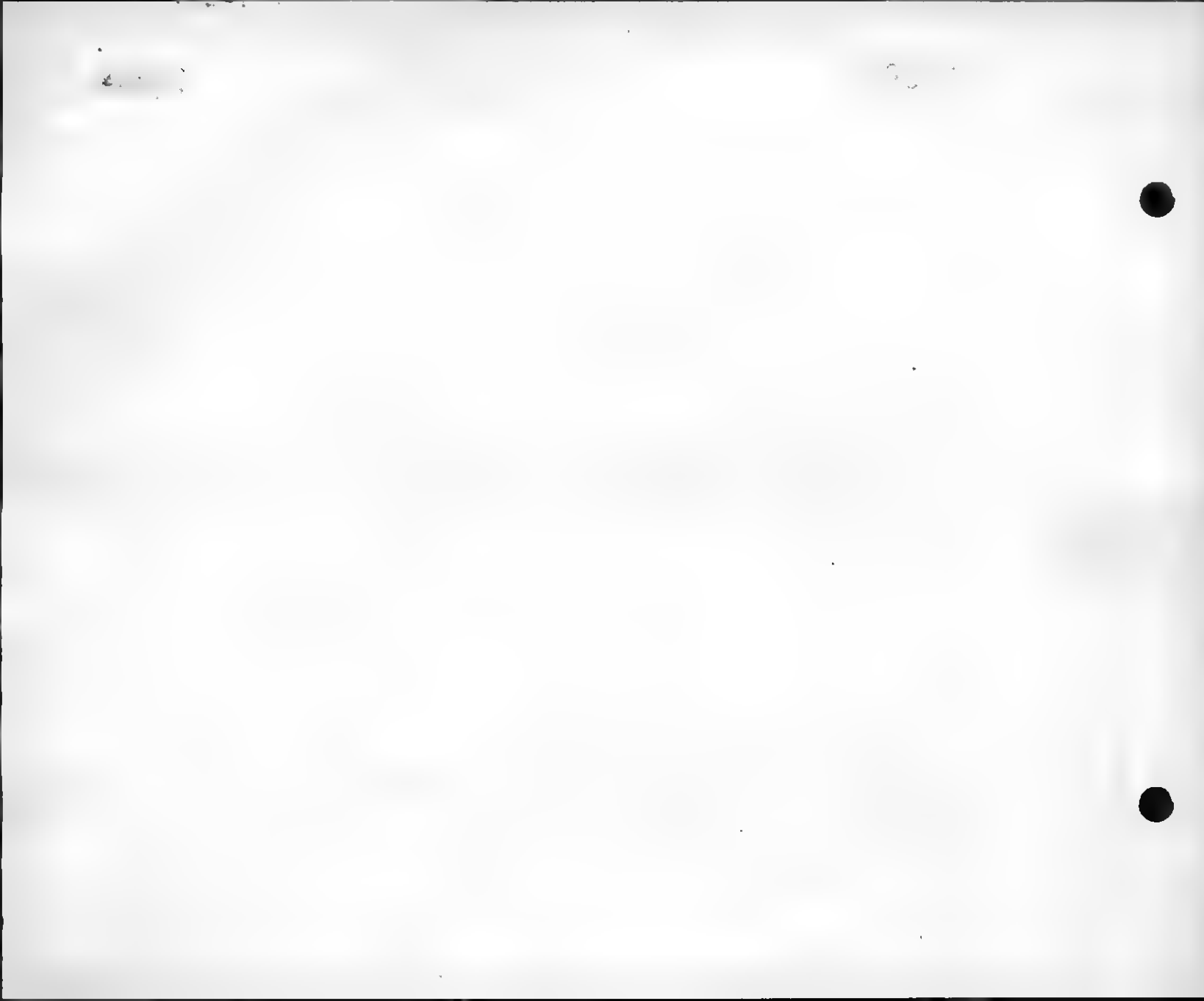
CERTIFICATE OF DEATH

14308

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>13 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>311 PINEWOOD AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth G. Bonsby</u>		4. DATE OF DEATH <u>Oct 6 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/30/01</u>
9. AGE (In years last birthday) <u>65</u> YRS		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE SCHOOL</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN J. CLEARY</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH P. McELROY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>JOHN C. BONSBY-827 RICHMOND AVE. SIL SPR MD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain tumor.</u> DUE TO (b) <u>237X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>3 mos</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> , 19 <u>66</u> , to <u>10/6</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/6</u> , 19 <u>66</u> , and that death occurred at <u>6:45 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Robert A. Mendelsohn</u>		22b. DATE SIGNED <u>10/6/1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT A. MENDELSON</u>		22d. ADDRESS <u>1015 SPRING ST. - SILVER SPRING, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/11/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST JOSEPH CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>West Roxbury, MASS</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC. SILVER SPRING, MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 10 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If necessary, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

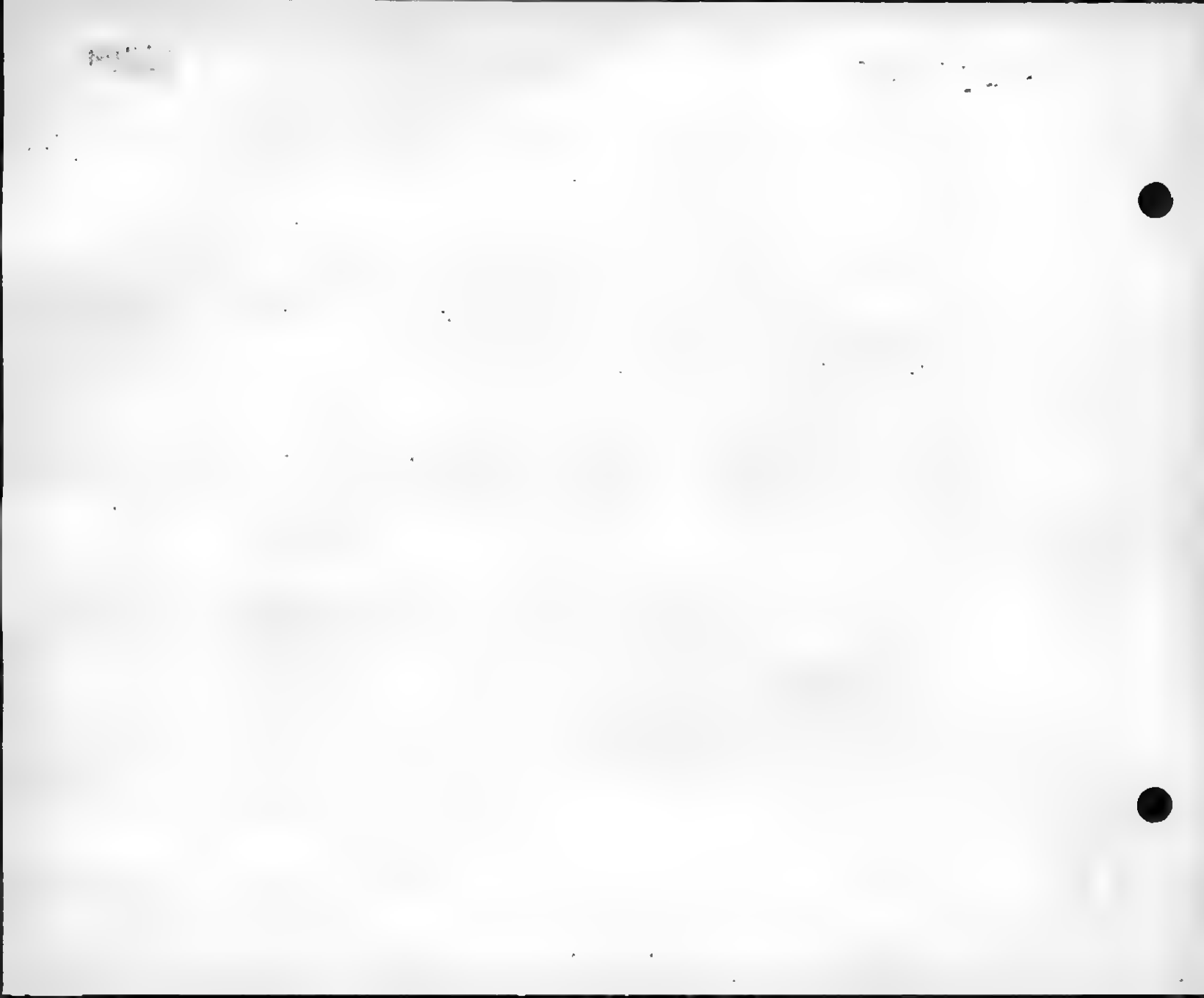
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14310

CERTIFICATE OF DEATH

14309

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Charles Boswell</u>		4. DATE OF DEATH <u>10 30 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-77</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Boswell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wilbur</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>218-24-0444</u>	
17. INFORMANT <u>Bessie E. Boswell - wife - same Item #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary edema, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>6 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/24, 1966</u> , to <u>10/30, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/29, 1966</u> , and that death occurred at <u>12:15 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>A. D. Bonifant</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>		22d. ADDRESS <u>Edley Springs, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/2/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>1331 Rock. Pike, Rodk.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE	
DATE <u>NOV 2 1966</u>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**14311**

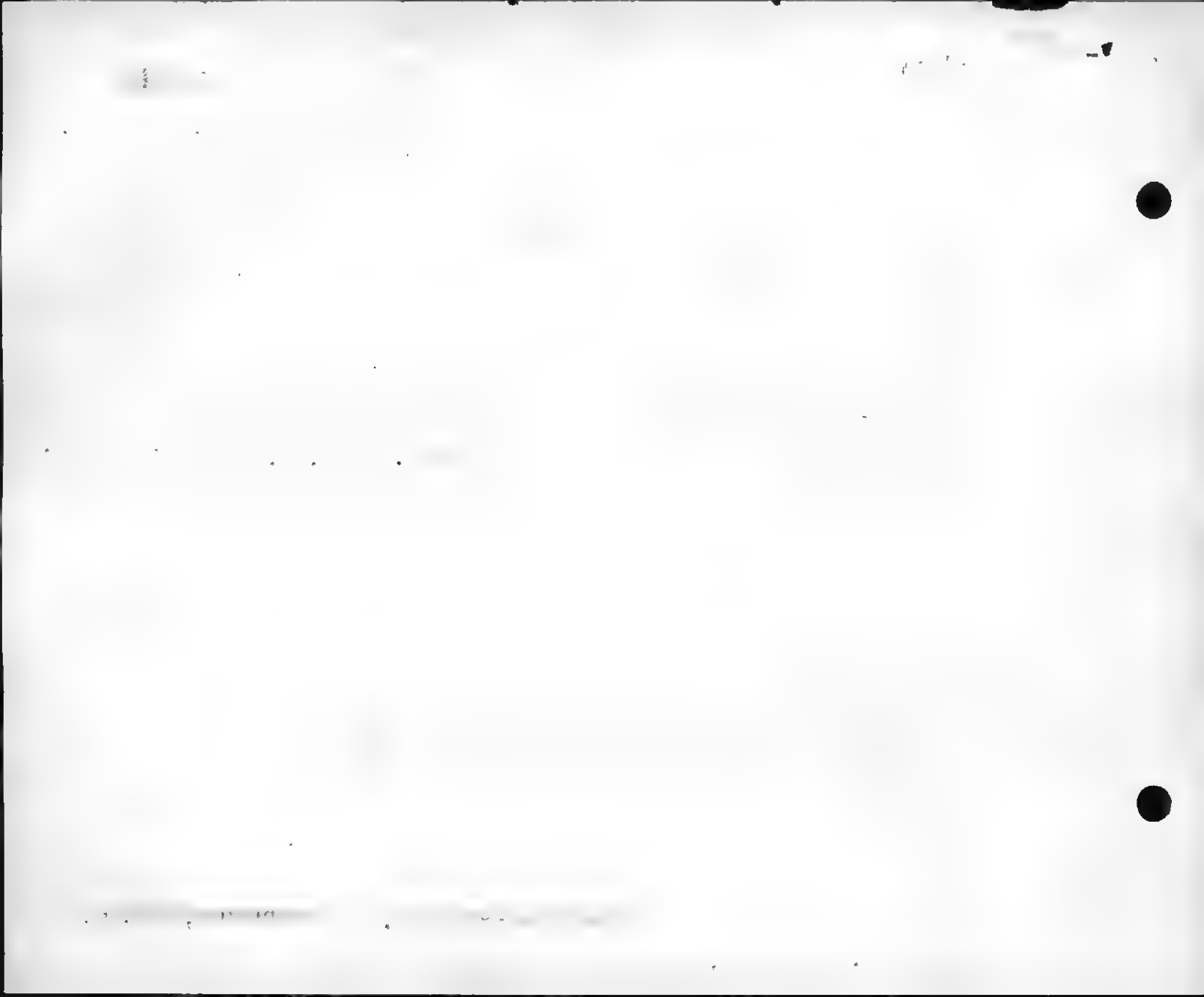
**CERTIFICATE OF DEATH**

**14310**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Trubekon Hospital</u>				d. STREET ADDRESS <u>9807 Broad St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>L</u> Last <u>Brady</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>5</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. CO. OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/12</u>	9. AGE (In years lost birthday) <u>54</u> yrs	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>28</u>	11. IF UNDER 24 HRS Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Columbia, Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Richard Stroketon</u>				14. MOTHER'S MAIDEN NAME <u>Annie L. Gollar</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Husband William Y. Brady, Jr.</u> Address <u>Same as Item 2.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary arteriosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>9/22</u>		20f. (City or town) (County) (State) <u>10/5</u> <u></u> <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9/22</u> , 19 <u>66</u> , to <u>10/5</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/5</u> , 19 <u>66</u> , and that death occurred at <u>11 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>10/5/66</u>		22c. PHYSICIAN'S NAME (Type) <u>10 F Kreuzburg</u>	
22d. ADDRESS <u>7852 16th St NW</u>				22e. ADDRESS <u>1000 12th St</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-10-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>DATE OCT 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14312

## CERTIFICATE OF DEATH

14312

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institutional; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>17 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>		d. STREET ADDRESS <u>7216 Spruce Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Philip Edward Bruscoe</u>		4. DATE OF DEATH <u>Oct 2 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 10 1883</u>
9 AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		11. BIRTH PLACE (County & State, or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Philip E Bruscoe</u>		14. MOTHER'S MAIDEN NAME <u>Williamia Humphrey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-52-4586</u>	
17. INFORMANT <u>Philip E Bruscoe Jr</u>		Address <u>7216 Spruce Ave Takoma Park Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line - (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> 6.05X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Cystitis</u> DUE TO (c) <u>Generalized Severe Vasculitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 6, 1966</u> , to <u>Oct 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/1/1966</u> , and that death occurred at <u>2 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. W. Meyers &amp; H. T. Morse</u>		22b. DATE SIGNED <u>10/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. Meyers &amp; H. T. Morse MD</u>		22d. ADDRESS <u>8323 Hadden Rd Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>10-8-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Lee Funeral Home, 300 4th St. N.E. Wash. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 10 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14313

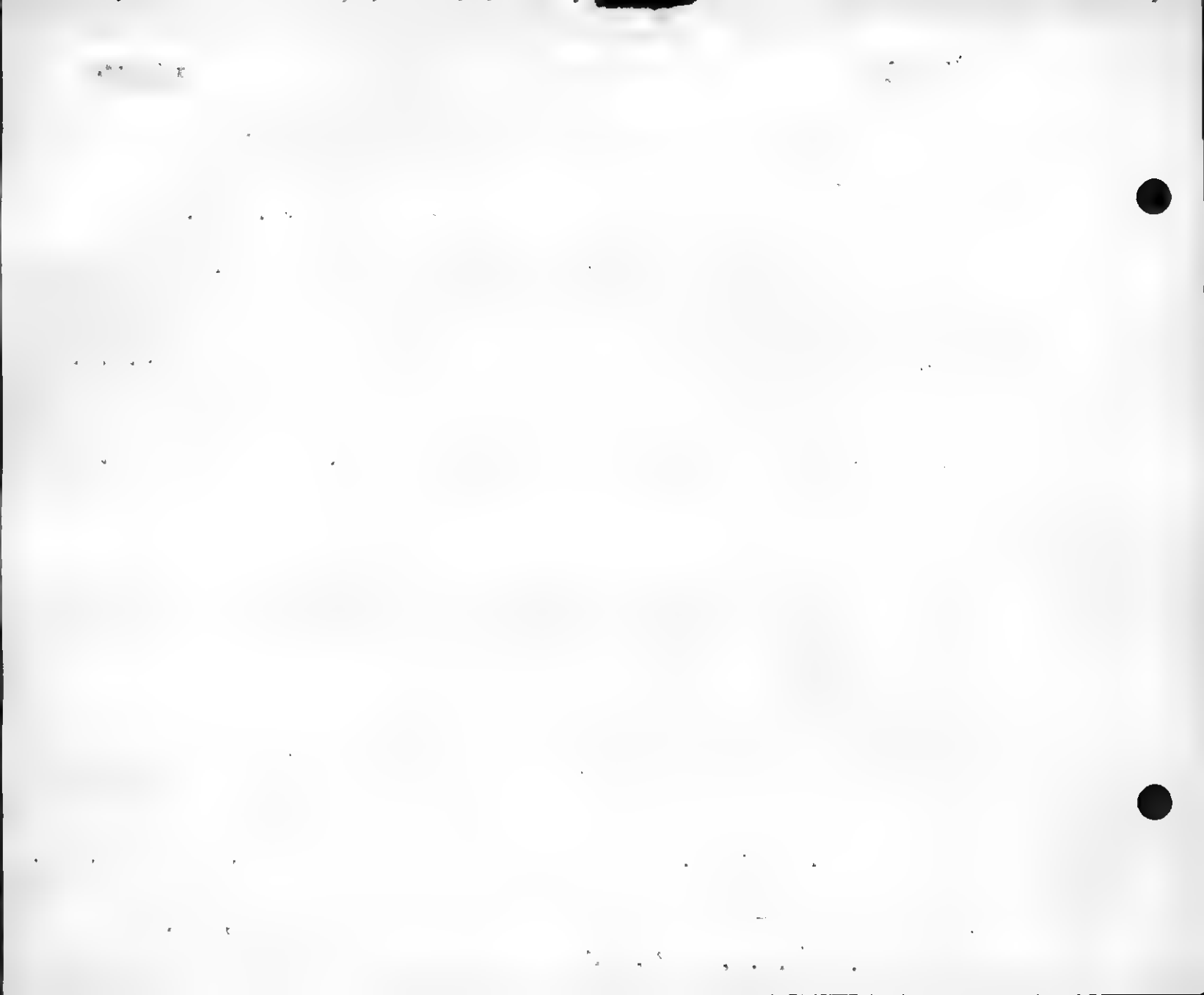
CERTIFICATE OF DEATH

14313

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b> c. LENGTH OF STAY IN 1b <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <b>District of Col.</b> b. COUNTY <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Marylander Hursing Home</b>		d. STREET ADDRESS <b>2721 Ordway St. N.W.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Adelaide Brooke</b>		4. DATE OF DEATH Month Day Year <b>Oct. 31 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-5-1886</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CIT. ZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Helen Virginia Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>- - -</b>		16. SOCIAL SECURITY NO. <b>- - -</b>	
17. INFORMANT <b>Herbert Brooke-</b>		Address <b>See Item No. 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/18</b> , 19 <b>65</b> , to <b>10/31</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>10/26</b> , 19 <b>66</b> , and that death occurred at <b>4:42 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>James P. Kerr</b>		22b. DATE SIGNED <b>10/31/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. James P. Kerr</b>		22d. ADDRESS <b>2661 Ridge Road, Damascus, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-2-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Warrenton Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Warrenton, Va.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 3 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14314

CERTIFICATE OF DEATH

14314

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>9002 Westmoreland Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Henry</u> Middle <u>Rhodes</u> Last <u>Brown</u>				<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>15</u> Year <u>1966</u>													
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1-14-94</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Government worker</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Michigan</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>									
<b>13. FATHER'S NAME</b> <u>Chester Brown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Harriet Rhodes</u>													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>WWI Army</u>				<b>16. SOCIAL SECURITY NO</b> <u>216-22-1076-A</u>		<b>17. INFORMANT</b> Address <u>Records - Washington Sanitarium &amp; Hospital</u>											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain pneumonia</u> (b) <u>Bacterial infection</u> (c) <u>Branchogenic carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>days</u> <u>months</u>									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>																	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>9/23</u> , 19 <u>66</u> , <b>to</b> <u>10/15</u> , 19 <u>66</u> <b>that (I) (we) last saw the deceased alive on</b> <u>19</u> , <b>and that death occurred at</b> <u>10/15</u> M, <b>from causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <u>Kenneth Cruze</u>				<b>22b. DATE SIGNED</b> <u>10/15/66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>KENNETH CRUZE</u>		<b>22d. ADDRESS</b>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u>		<b>23b. DATE THEREOF</b> <u>Oct 17, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Crematory</u>		<b>23d. LOCATION (City or town) (County) (State)</b> <u>Prince Geo. Co. Md</u>											
<b>24. FUNERAL DIRECTOR</b> <u>Arthur Walters</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>				<b>25b. REGISTRAR'S SIGNATURE</b>									
<b>25c. ADDRESS</b> <u>251 Carroll Street, N.E.</u>				<b>25d. DATE</b> <u>OCT 18 1966</u>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the Death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

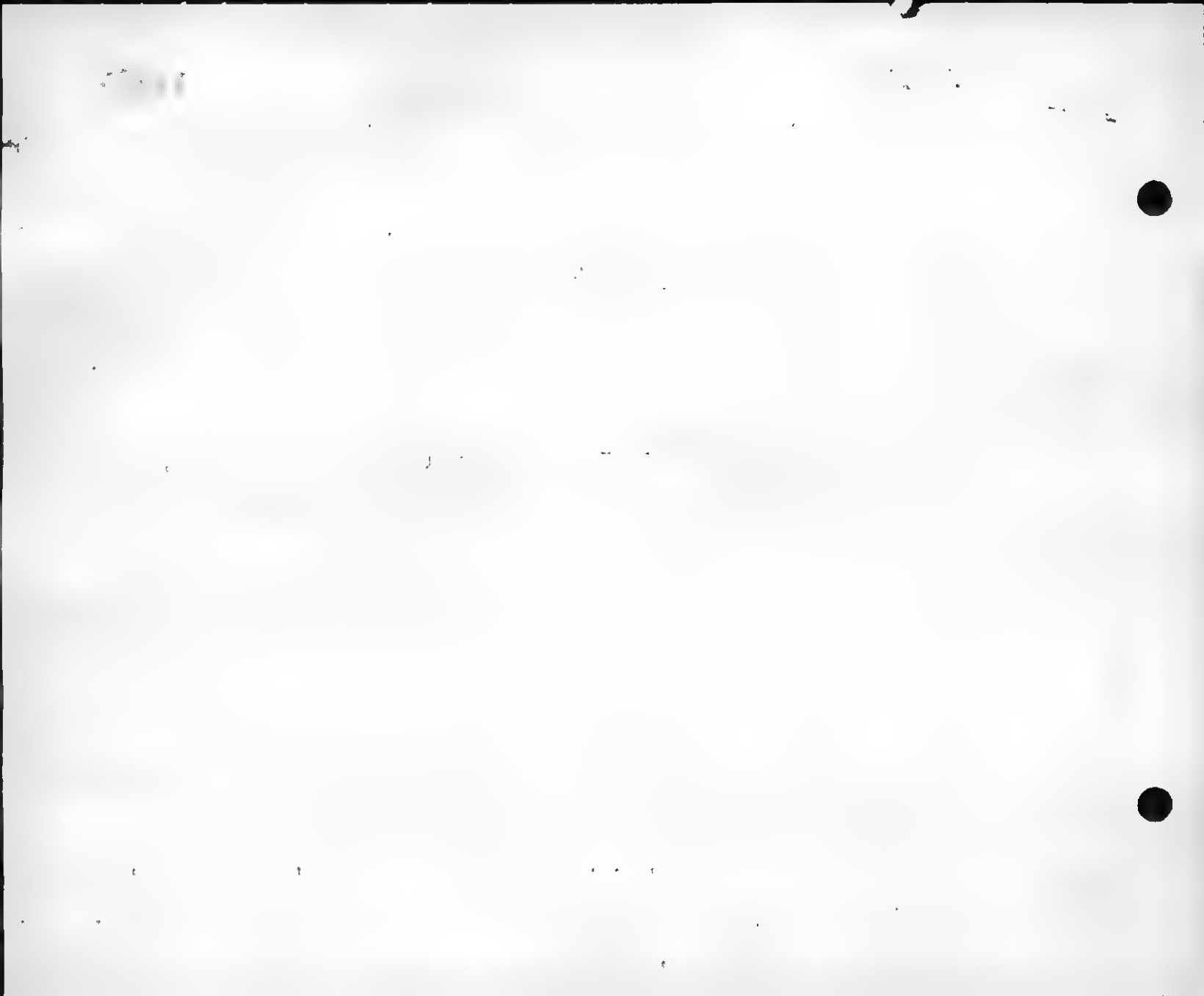
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14315

CERTIFICATE OF DEATH

14315

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN 1b <b>23 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>Rt. 3 Box 193</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>MELVIN RUSSELLE BURDETTE</b>				4 DATE OF DEATH Month Day Year <b>OCTOBER 31 1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/12/05</b>	
9. AGE (In years last birthday) yrs. <b>61</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMPLOYED</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>LUTHER BURDETTE</b>			
14. MOTHER'S MAIDEN NAME <b>ELLA CUTSAIL</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO <b>217-28-7981</b>				17. INFORMANT <b>HOSPITAL RECORDS</b> Address <b>OLNEY, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mutantative carcinomatosis - probable pancreas</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>66</b> to <b>Oct. 31</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10-29</b> 19 <b>66</b> , and that death occurred at <b>9:40 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Frederick Moomau M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-31-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK MOOMAU, M.D.</b>				22d. ADDRESS <b>MEDICAL CENTER, SANDY SPRING, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/3/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hyattstown Methodist</b>		23d. LOCATION (City or Town) (County) (State) <b>Hyattstown Montg. Md.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

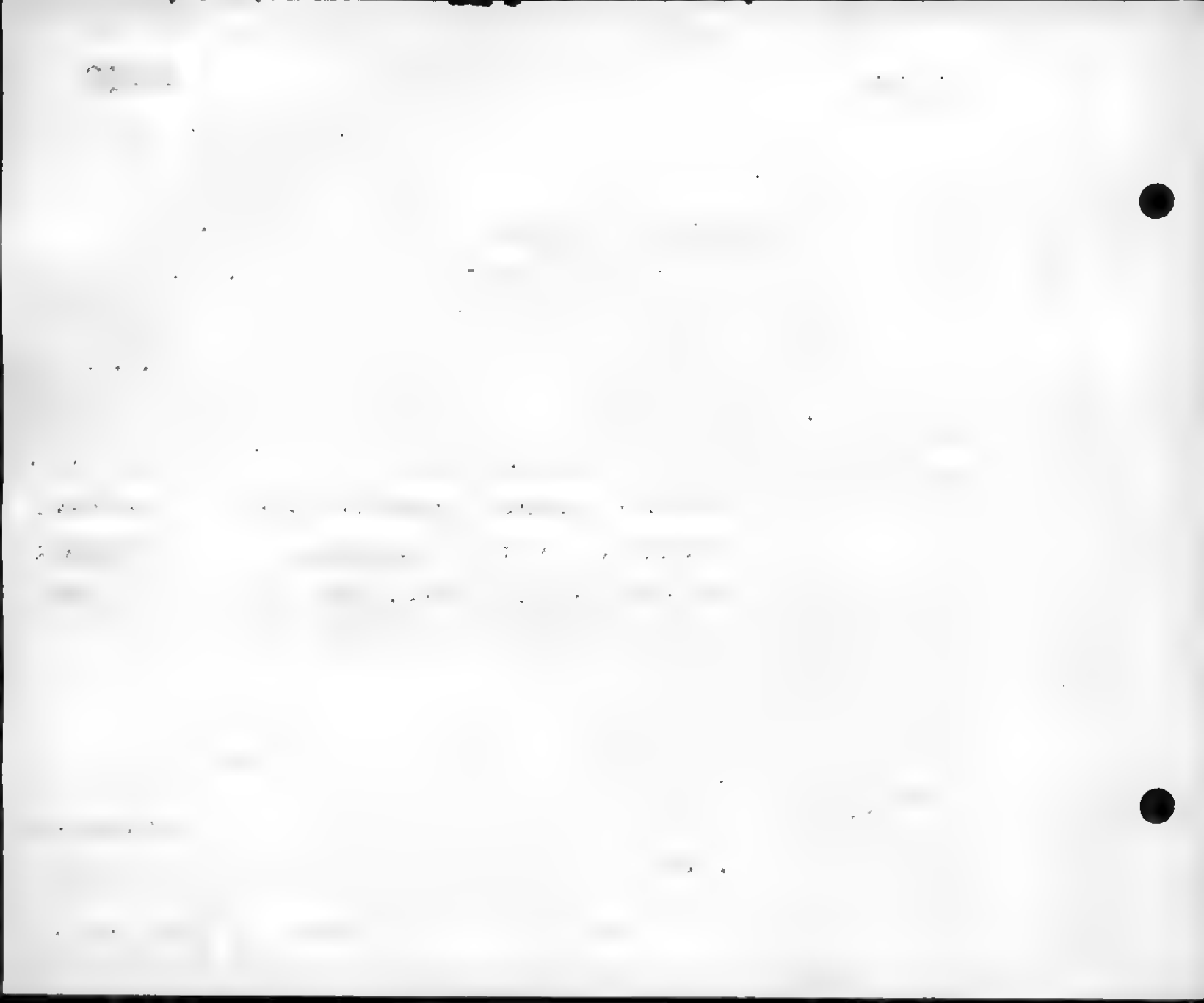
14316

14316

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethesda Silver Spring NursingHome</b>		d. STREET ADDRESS <b>4701 Willard Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Dwight</b> Middle <b>Nutting</b> Last <b>Burnham</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>23</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/23/1885</b>
9. AGE (In years last birthday) <b>81</b> yrs		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>23</b> Hours <b>00</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Beatrice, Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oliver R. Burnham</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Nutting</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>- - -</b>	
17. INFORMANT <b>A. deMouy Spottswood</b>		<b>4701 Willard Ave Chevy Chase, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) <b>ASHD &amp; HEART FAILURE</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , 19 <b>Oct 23</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>10-23</b> 19 <b>66</b> , and that death occurred at <b>3 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Philip R. James</b>		22b. DATE SIGNED <b>10-23-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>PHILIP R. JAMES</b>		22d. ADDRESS <b>Washington Clinic, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Crementation</b>		23b. DATE THEREOF <b>10/24/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md</b>	
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER SONS</b>		25. REC'D BY REGISTRAR <b>WASH. D.C.</b>	
25a. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 27 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14317

## CERTIFICATE OF DEATH

14317

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in lb <u>12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>9119 RIVER ROAD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES H. CARRICO</u>		4. DATE OF DEATH Month Day Year <u>OCT 3 19 66</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/84</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RIDING STABLE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HENRY William CARRICO</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH BROOKS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>22.0-32-5847</u>	
17. INFORMANT <u>MAE CARRICO - WIFE - SAME</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Metastatic Kidney Invasion</u> DUE TO (c) <u>Ca Prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> , 19 <u>66</u> to <u>10/3</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/3</u> 19 <u>66</u> and that death occurred at <u>10:40</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Brewer</u> M.D.		22b. DATE SIGNED <u>10/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Brewer</u>		22d. ADDRESS <u>8505 Old Geo. Town Rd. Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6 Oct 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gavlars Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>WASH. D.C.</u>	
25d. DATE <u>OCT 7 1966</u>		25e. ADDRESS <u>5130 Wise Ave NW</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

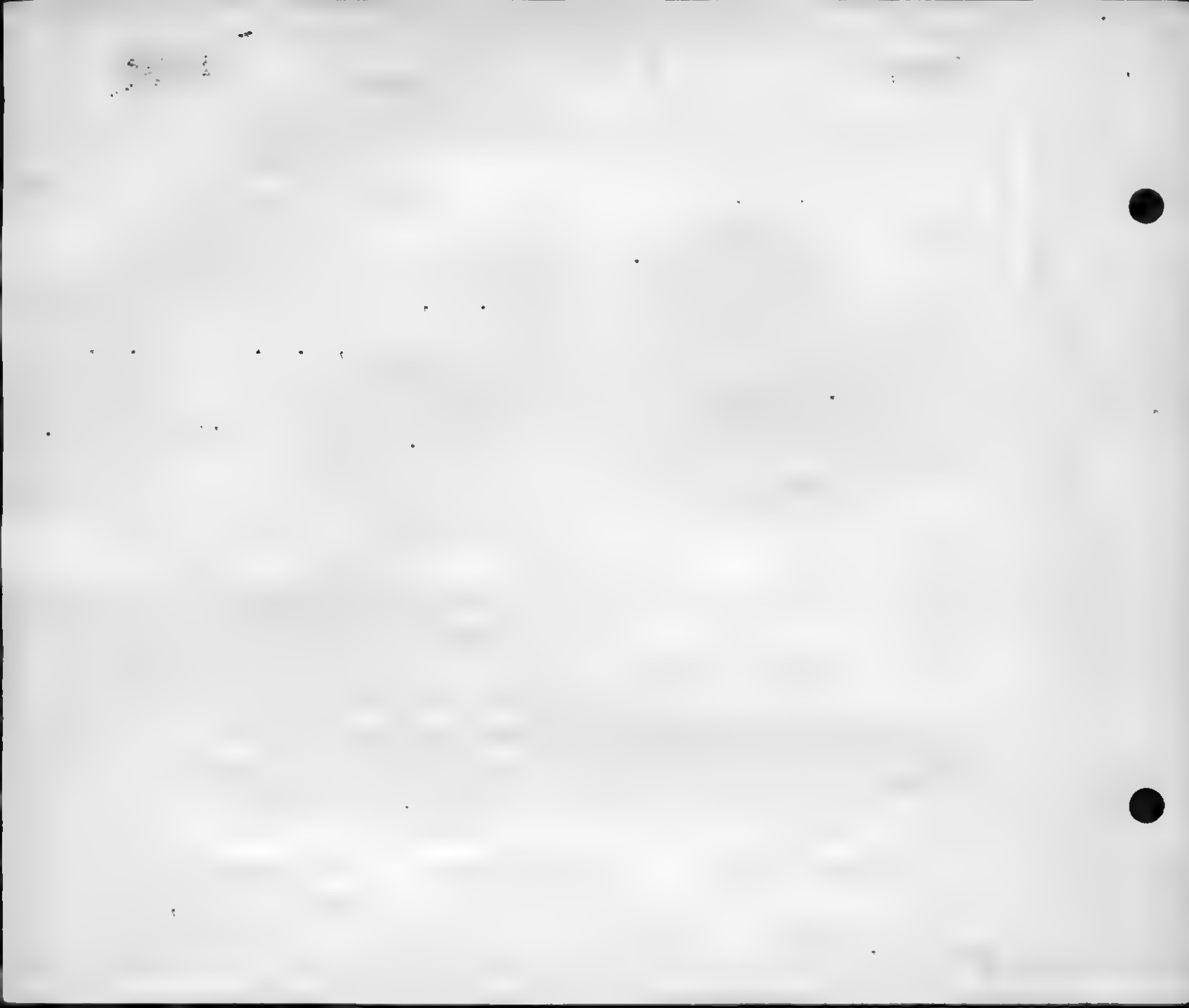
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1121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14318					14318				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				
c. LENGTH OF STAY in 1b <u>5 yrs</u>					d. STREET ADDRESS <u>9702 Carriage Road</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9702 Carriage Road</u>					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>MARY V. CASSIDY</u>					4. DATE OF DEATH <u>OCTOBER 31 1966</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH <u>Feb. 28, 1896</u>				
9. AGE (In years last birthday) <u>70</u> yrs.					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>3</u> Hours <u>1</u> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>					12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>				
13. FATHER'S NAME <u>Ward V. Coates</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth J. Quinn</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>Unknown</u>				
17. INFORMANT <u>Husband</u>					Address <u>Same as Item 2.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>metastasis of carcinoma of pancreas</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>8 months</u> <u>1 yr</u>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>operated 2 times</u>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>					20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. CITY OR TOWN <u>Rockville</u>					20f. (City or town) (County) (State) <u>Rockville, Maryland</u>				
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>present</u> , that (I) (we) last saw the deceased alive on <u>11/30/1966</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Charles Savarese, M.D.</u>					22b. DATE SIGNED <u>10/31/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>CHARLES SAVARESE, MD</u>					22d. ADDRESS <u>11125 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>11-3-66</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>					23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>				
24 FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>					25a. REC'D BY REGISTRAR DATE <u>NOV 1 1966</u>				
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									



**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14319

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14319

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY N 1b <u>48 hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8200 Wisconsin Ave.</u>		d. STREET ADDRESS <u>411 Crownview</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>ANN</u> Middle <u>OPIE</u> Last <u>CHANCELLOR</u>		4 DATE OF DEATH Month <u>Oct</u> Day <u>22</u> Year <u>1966</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/1/44</u>
9 AGE (In years last birthday) <u>22</u> yrs.		10 UNDER 1 YEAR Months <u>22</u> Days <u>22</u> Hours <u>22</u> Min <u>22</u>	11 UNDER 24 HRS Months <u>22</u> Days <u>22</u> Hours <u>22</u> Min <u>22</u>
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>AL OPIE CHANCELLOR</u>		14. MOTHER'S MAIDEN NAME <u>ROTH A HOLZMUELLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>578 60 1288</u>	
17. INFORMANT <u>Dr. David Anderson N14</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) DUE TO (d) DUE TO (e) DUE TO (f) DUE TO (g) DUE TO (h) DUE TO (i) DUE TO (j) DUE TO (k) DUE TO (l) DUE TO (m) DUE TO (n) DUE TO (o) DUE TO (p) DUE TO (q) DUE TO (r) DUE TO (s) DUE TO (t) DUE TO (u) DUE TO (v) DUE TO (w) DUE TO (x) DUE TO (y) DUE TO (z) DUE TO (aa) DUE TO (ab) DUE TO (ac) DUE TO (ad) DUE TO (ae) DUE TO (af) DUE TO (ag) DUE TO (ah) DUE TO (ai) DUE TO (aj) DUE TO (ak) DUE TO (al) DUE TO (am) DUE TO (an) DUE TO (ao) DUE TO (ap) DUE TO (aq) DUE TO (ar) DUE TO (as) DUE TO (at) DUE TO (au) DUE TO (av) DUE TO (aw) DUE TO (ax) DUE TO (ay) DUE TO (az) DUE TO (ba) DUE TO (bb) DUE TO (bc) DUE TO (bd) DUE TO (be) DUE TO (bf) DUE TO (bg) DUE TO (bh) DUE TO (bi) DUE TO (bj) DUE TO (bk) DUE TO (bl) DUE TO (bm) DUE TO (bn) DUE TO (bo) DUE TO (bp) DUE TO (bq) DUE TO (br) DUE TO (bs) DUE TO (bt) DUE TO (bu) DUE TO (bv) DUE TO (bw) DUE TO (bx) DUE TO (by) DUE TO (bz) DUE TO (ca) DUE TO (cb) DUE TO (cc) DUE TO (cd) DUE TO (ce) DUE TO (cf) DUE TO (cg) DUE TO (ch) DUE TO (ci) DUE TO (cj) DUE TO (ck) DUE TO (cl) DUE TO (cm) DUE TO (cn) DUE TO (co) DUE TO (cp) DUE TO (cq) DUE TO (cr) DUE TO (cs) DUE TO (ct) DUE TO (cu) DUE TO (cv) DUE TO (cw) DUE TO (cx) DUE TO (cy) DUE TO (cz) DUE TO (da) DUE TO (db) DUE TO (dc) DUE TO (dd) DUE TO (de) DUE TO (df) DUE TO (dg) DUE TO (dh) DUE TO (di) DUE TO (dj) DUE TO (dk) DUE TO (dl) DUE TO (dm) DUE TO (dn) DUE TO (do) DUE TO (dp) DUE TO (dq) DUE TO (dr) DUE TO (ds) DUE TO (dt) DUE TO (du) DUE TO (dv) DUE TO (dw) DUE TO (dx) DUE TO (dy) DUE TO (dz) DUE TO (ea) DUE TO (eb) DUE TO (ec) DUE TO (ed) DUE TO (ee) DUE TO (ef) DUE TO (eg) DUE TO (eh) DUE TO (ei) DUE TO (ej) DUE TO (ek) DUE TO (el) DUE TO (em) DUE TO (en) DUE TO (eo) DUE TO (ep) DUE TO (eq) DUE TO (er) DUE TO (es) DUE TO (et) DUE TO (eu) DUE TO (ev) DUE TO (ew) DUE TO (ex) DUE TO (ey) DUE TO (ez) DUE TO (fa) DUE TO (fb) DUE TO (fc) DUE TO (fd) DUE TO (fe) DUE TO (ff) DUE TO (fg) DUE TO (fh) DUE TO (fi) DUE TO (fj) DUE TO (fk) DUE TO (fl) DUE TO (fm) DUE TO (fn) DUE TO (fo) DUE TO (fp) DUE TO (fq) DUE TO (fr) DUE TO (fs) DUE TO (ft) DUE TO (fu) DUE TO (fv) DUE TO (fw) DUE TO (fx) DUE TO (fy) DUE TO (fz) DUE TO (ga) DUE TO (gb) DUE TO (gc) DUE TO (gd) DUE TO (ge) DUE TO (gf) DUE TO (gg) DUE TO (gh) DUE TO (gi) DUE TO (gj) DUE TO (gk) DUE TO (gl) DUE TO (gm) DUE TO (gn) DUE TO (go) DUE TO (gp) DUE TO (gq) DUE TO (gr) DUE TO (gs) DUE TO (gt) DUE TO (gu) DUE TO (gv) DUE TO (gw) DUE TO (gx) DUE TO (gy) DUE TO (gz) DUE TO (ha) DUE TO (hb) DUE TO (hc) DUE TO (hd) DUE TO (he) DUE TO (hf) DUE TO (hg) DUE TO (hh) DUE TO (hi) DUE TO (hj) DUE TO (hk) DUE TO (hl) DUE TO (hm) DUE TO (hn) DUE TO (ho) DUE TO (hp) DUE TO (hq) DUE TO (hr) DUE TO (hs) DUE TO (ht) DUE TO (hu) DUE TO (hv) DUE TO (hw) DUE TO (hx) DUE TO (hy) DUE TO (hz) DUE TO (ia) DUE TO (ib) DUE TO (ic) DUE TO (id) DUE TO (ie) DUE TO (if) DUE TO (ig) DUE TO (ih) DUE TO (ii) DUE TO (ij) DUE TO (ik) DUE TO (il) DUE TO (im) DUE TO (in) DUE TO (io) DUE TO (ip) DUE TO (iq) DUE TO (ir) DUE TO (is) DUE TO (it) DUE TO (iu) DUE TO (iv) DUE TO (iw) DUE TO (ix) DUE TO (iy) DUE TO (iz) DUE TO (ja) DUE TO (jb) DUE TO (jc) DUE TO (jd) DUE TO (je) DUE TO (jf) DUE TO (jg) DUE TO (jh) DUE TO (ji) DUE TO (jj) DUE TO (jk) DUE TO (jl) DUE TO (jm) DUE TO (jn) DUE TO (jo) DUE TO (jp) DUE TO (jq) DUE TO (jr) DUE TO (js) DUE TO (jt) DUE TO (ju) DUE TO (jv) DUE TO (jw) DUE TO (jx) DUE TO (jy) DUE TO (jz) DUE TO (ka) DUE TO (kb) DUE TO (kc) DUE TO (kd) DUE TO (ke) DUE TO (kf) DUE TO (kg) DUE TO (kh) DUE TO (ki) DUE TO (kj) DUE TO (kk) DUE TO (kl) DUE TO (km) DUE TO (kn) DUE TO (ko) DUE TO (kp) DUE TO (kq) DUE TO (kr) DUE TO (ks) DUE TO (kt) DUE TO (ku) DUE TO (kv) DUE TO (kw) DUE TO (kx) DUE TO (ky) DUE TO (kz) DUE TO (la) DUE TO (lb) DUE TO (lc) DUE TO (ld) DUE TO (le) DUE TO (lf) DUE TO (lg) DUE TO (lh) DUE TO (li) DUE TO (lj) DUE TO (lk) DUE TO (ll) DUE TO (lm) DUE TO (ln) DUE TO (lo) DUE TO (lp) DUE TO (lq) DUE TO (lr) DUE TO (ls) DUE TO (lt) DUE TO (lu) DUE TO (lv) DUE TO (lw) DUE TO (lx) DUE TO (ly) DUE TO (lz) DUE TO (ma) DUE TO (mb) DUE TO (mc) DUE TO (md) DUE TO (me) DUE TO (mf) DUE TO (mg) DUE TO (mh) DUE TO (mi) DUE TO (mj) DUE TO (mk) DUE TO (ml) DUE TO (mn) DUE TO (mo) DUE TO (mp) DUE TO (mq) DUE TO (mr) DUE TO (ms) DUE TO (mt) DUE TO (mu) DUE TO (mv) DUE TO (mw) DUE TO (mx) DUE TO (my) DUE TO (mz) DUE TO (na) DUE TO (nb) DUE TO (nc) DUE TO (nd) DUE TO (ne) DUE TO (nf) DUE TO (ng) DUE TO (nh) DUE TO (ni) DUE TO (nj) DUE TO (nk) DUE TO (nl) DUE TO (nm) DUE TO (nn) DUE TO (no) DUE TO (np) DUE TO (nq) DUE TO (nr) DUE TO (ns) DUE TO (nt) DUE TO (nu) DUE TO (nv) DUE TO (nw) DUE TO (nx) DUE TO (ny) DUE TO (nz) DUE TO (oa) DUE TO (ob) DUE TO (oc) DUE TO (od) DUE TO (oe) DUE TO (of) DUE TO (og) DUE TO (oh) DUE TO (oi) DUE TO (oj) DUE TO (ok) DUE TO (ol) DUE TO (om) DUE TO (on) DUE TO (oo) DUE TO (op) DUE TO (oq) DUE TO (or) DUE TO (os) DUE TO (ot) DUE TO (ou) DUE TO (ov) DUE TO (ow) DUE TO (ox) DUE TO (oy) DUE TO (oz) DUE TO (pa) DUE TO (pb) DUE TO (pc) DUE TO (pd) DUE TO (pe) DUE TO (pf) DUE TO (pg) DUE TO (ph) DUE TO (pi) DUE TO (pj) DUE TO (pk) DUE TO (pl) DUE TO (pm) DUE TO (pn) DUE TO (po) DUE TO (pp) DUE TO (pq) DUE TO (pr) DUE TO (ps) DUE TO (pt) DUE TO (pu) DUE TO (pv) DUE TO (pw) DUE TO (px) DUE TO (py) DUE TO (pz) DUE TO (qa) DUE TO (qb) DUE TO (qc) DUE TO (qd) DUE TO (qe) DUE TO (qf) DUE TO (qg) DUE TO (qh) DUE TO (qi) DUE TO (qj) DUE TO (qk) DUE TO (ql) DUE TO (qm) DUE TO (qn) DUE TO (qo) DUE TO (qp) DUE TO (qq) DUE TO (qr) DUE TO (qs) DUE TO (qt) DUE TO (qu) DUE TO (qv) DUE TO (qw) DUE TO (qx) DUE TO (qy) DUE TO (qz) DUE TO (ra) DUE TO (rb) DUE TO (rc) DUE TO (rd) DUE TO (re) DUE TO (rf) DUE TO (rg) DUE TO (rh) DUE TO (ri) DUE TO (rj) DUE TO (rk) DUE TO (rl) DUE TO (rm) DUE TO (rn) DUE TO (ro) DUE TO (rp) DUE TO (rq) DUE TO (rr) DUE TO (rs) DUE TO (rt) DUE TO (ru) DUE TO (rv) DUE TO (rw) DUE TO (rx) DUE TO (ry) DUE TO (rz) DUE TO (sa) DUE TO (sb) DUE TO (sc) DUE TO (sd) DUE TO (se) DUE TO (sf) DUE TO (sg) DUE TO (sh) DUE TO (si) DUE TO (sj) DUE TO (sk) DUE TO (sl) DUE TO (sm) DUE TO (sn) DUE TO (so) DUE TO (sp) DUE TO (sq) DUE TO (sr) DUE TO (ss) DUE TO (st) DUE TO (su) DUE TO (sv) DUE TO (sw) DUE TO (sx) DUE TO (sy) DUE TO (sz) DUE TO (ta) DUE TO (tb) DUE TO (tc) DUE TO (td) DUE TO (te) DUE TO (tf) DUE TO (tg) DUE TO (th) DUE TO (ti) DUE TO (tj) DUE TO (tk) DUE TO (tl) DUE TO (tm) DUE TO (tn) DUE TO (to) DUE TO (tp) DUE TO (tq) DUE TO (tr) DUE TO (ts) DUE TO (tt) DUE TO (tu) DUE TO (tv) DUE TO (tw) DUE TO (tx) DUE TO (ty) DUE TO (tz) DUE TO (ua) DUE TO (ub) DUE TO (uc) DUE TO (ud) DUE TO (ue) DUE TO (uf) DUE TO (ug) DUE TO (uh) DUE TO (ui) DUE TO (uj) DUE TO (uk) DUE TO (ul) DUE TO (um) DUE TO (un) DUE TO (uo) DUE TO (up) DUE TO (uq) DUE TO (ur) DUE TO (us) DUE TO (ut) DUE TO (uu) DUE TO (uv) DUE TO (uw) DUE TO (ux) DUE TO (uy) DUE TO (uz) DUE TO (va) DUE TO (vb) DUE TO (vc) DUE TO (vd) DUE TO (ve) DUE TO (vf) DUE TO (vg) DUE TO (vh) DUE TO (vi) DUE TO (vj) DUE TO (vk) DUE TO (vl) DUE TO (vm) DUE TO (vn) DUE TO (vo) DUE TO (vp) DUE TO (vq) DUE TO (vr) DUE TO (vs) DUE TO (vt) DUE TO (vu) DUE TO (vv) DUE TO (vw) DUE TO (vx) DUE TO (vy) DUE TO (vz) DUE TO (wa) DUE TO (wb) DUE TO (wc) DUE TO (wd) DUE TO (we) DUE TO (wf) DUE TO (wg) DUE TO (wh) DUE TO (wi) DUE TO (wj) DUE TO (wk) DUE TO (wl) DUE TO (wm) DUE TO (wn) DUE TO (wo) DUE TO (wp) DUE TO (wq) DUE TO (wr) DUE TO (ws) DUE TO (wt) DUE TO (wu) DUE TO (wv) DUE TO (ww) DUE TO (wx) DUE TO (wy) DUE TO (wz) DUE TO (xa) DUE TO (xb) DUE TO (xc) DUE TO (xd) DUE TO (xe) DUE TO (xf) DUE TO (xg) DUE TO (xh) DUE TO (xi) DUE TO (xj) DUE TO (xk) DUE TO (xl) DUE TO (xm) DUE TO (xn) DUE TO (xo) DUE TO (xp) DUE TO (xq) DUE TO (xr) DUE TO (xs) DUE TO (xt) DUE TO (xu) DUE TO (xv) DUE TO (xw) DUE TO (xx) DUE TO (xy) DUE TO (xz) DUE TO (ya) DUE TO (yb) DUE TO (yc) DUE TO (yd) DUE TO (ye) DUE TO (yf) DUE TO (yg) DUE TO (yh) DUE TO (yi) DUE TO (yj) DUE TO (yk) DUE TO (yl) DUE TO (ym) DUE TO (yn) DUE TO (yo) DUE TO (yp) DUE TO (yq) DUE TO (yr) DUE TO (ys) DUE TO (yt) DUE TO (yu) DUE TO (yv) DUE TO (yw) DUE TO (yx) DUE TO (yz) DUE TO (za) DUE TO (zb) DUE TO (zc) DUE TO (zd) DUE TO (ze) DUE TO (zf) DUE TO (zg) DUE TO (zh) DUE TO (zi) DUE TO (zj) DUE TO (zk) DUE TO (zl) DUE TO (zm) DUE TO (zn) DUE TO (zo) DUE TO (zp) DUE TO (zq) DUE TO (zr) DUE TO (zs) DUE TO (zt) DUE TO (zu) DUE TO (zv) DUE TO (zw) DUE TO (zx) DUE TO (zy) DUE TO (zz)			

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  
Jumped down elevator shaft 11th floor.

20c. TIME OF INJURY Month, Day Year  
Hour 7 a.m. pm 10 22 1966

20d. INJURY OCCURRED While ☐ at work Not While ☒ at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
Building

20f. (City or town) (County) (State)  
Bethesda Montg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE John H. Bell M.D.  
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒  
Address (Street, city, town, or county)

22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

23b. DATE THEREOF  
10/27/66

23c. NAME OF CEMETERY OR CREMATORY  
Odd Fellows Cemetery

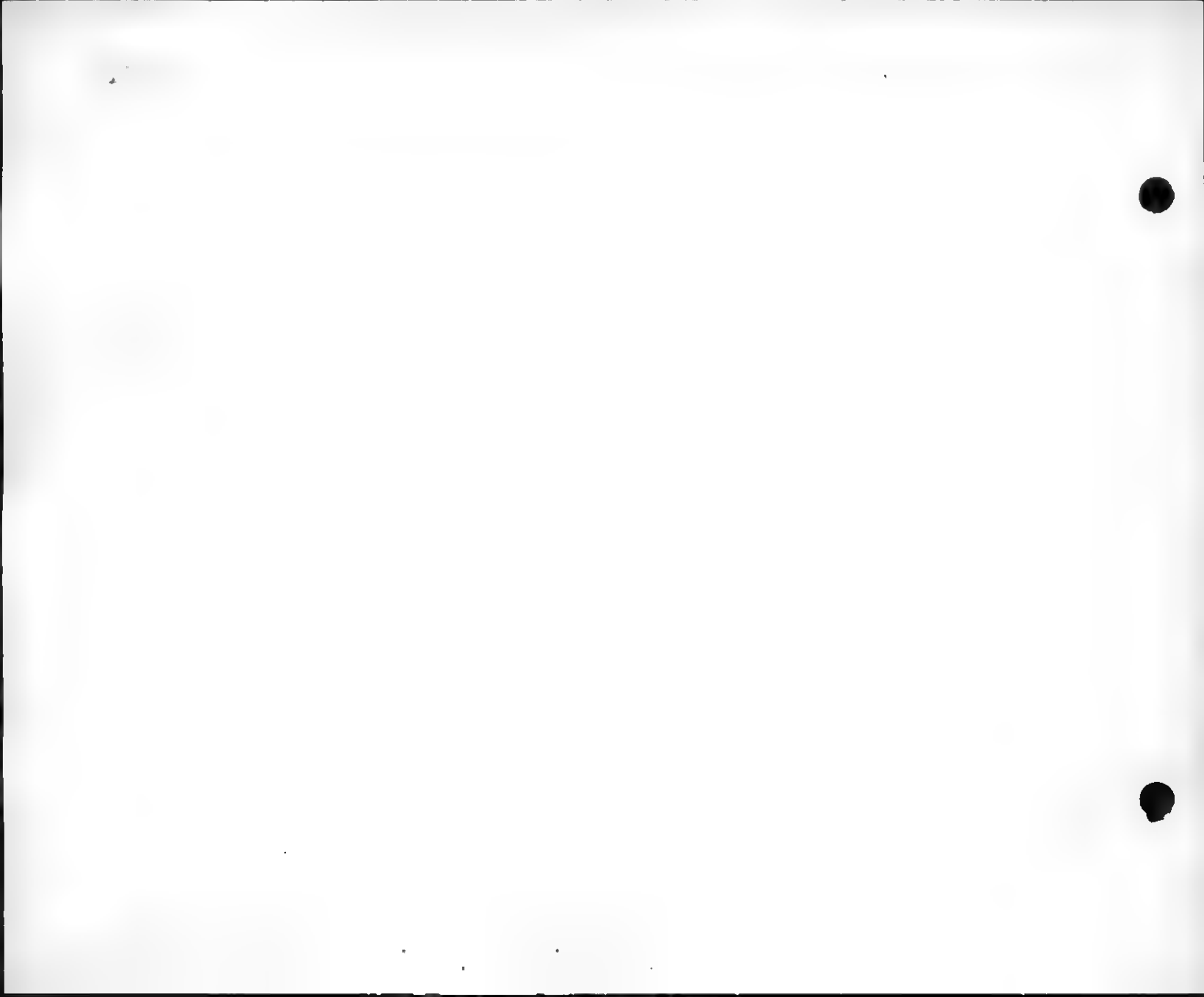
23d. LOCATION (City or Town) (County) (State)  
Milford, Delaware

24. FUNERAL DIRECTOR  
Everly-Wheatley Funeral Home, Alexandria, Va.

25a. REC'D BY REGISTRAR  
1500 W. Braddock Rd.

25b. REGISTRAR'S SIGNATURE  
Charles Judge

DATE  
OCT 27 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4, together with carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

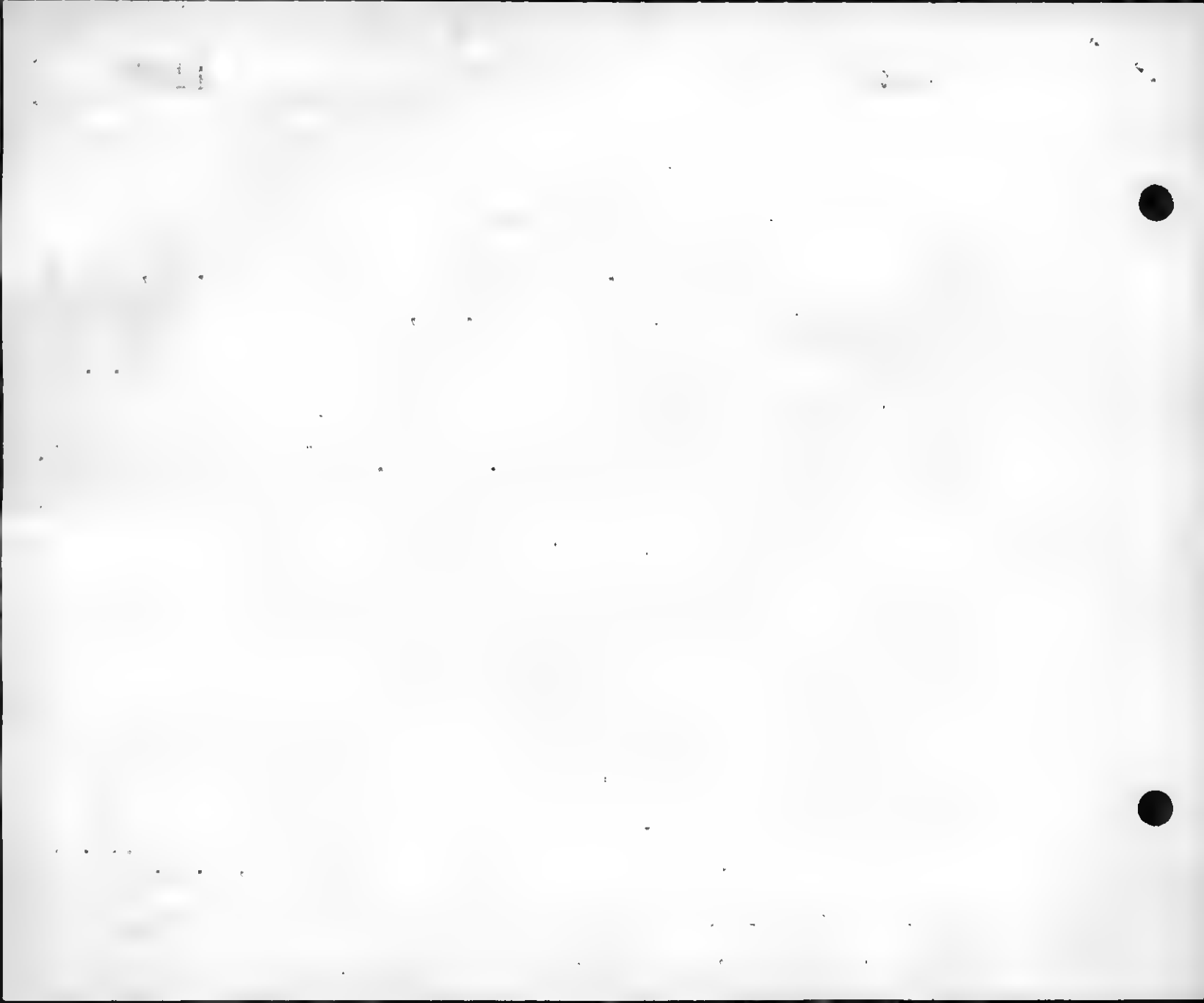
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14320

CERTIFICATE OF DEATH

14320

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>7 Months 28 Days.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethesda-Silver Spring Nursing Home</b>		d. STREET ADDRESS <b>4104 Rosemary Street</b>	
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>S.</b> Last <b>CHRISTIAN</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>14,</b> Year <b>19 66</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 29, 1896</b>
9. AGE (In years last birthday) <b>70</b> yrs		IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Kansas</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>Upshur Snider</b>		14. MOTHER'S MAIDEN NAME <b>Mary Robbins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17 INFORMANT <b>Daughter</b> Address <b>Same as Item 2.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emphysema</b> DUE TO <b>0032</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Healed pulmonary tuberculosis</b> DUE TO <b>4 years</b> (c) <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 19, 1962</b> to <b>Oct 14, 1966</b> that (I) (we) last saw the deceased alive on <b>October 14, 1966</b> and that death occurred at <b>10:35 AM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Thomas S. Sappington</b> M.D.		22b. DATE SIGNED <b>10-14-66</b>	
22c PHYSICIAN'S NAME (Type) <b>THOMAS S. SAPPINGTON</b>		22d. ADDRESS <b>2233 Wisconsin Ave., N.W. Washington, D. C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 10-15-66</b>		23b. DATE THEREOF <b>10-15-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Highland Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Iola, Kansas</b>	
24 FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a REC'D BY REGISTRAR <b>Charles Judge</b> 25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>OCT 19 1966</b>			





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14321

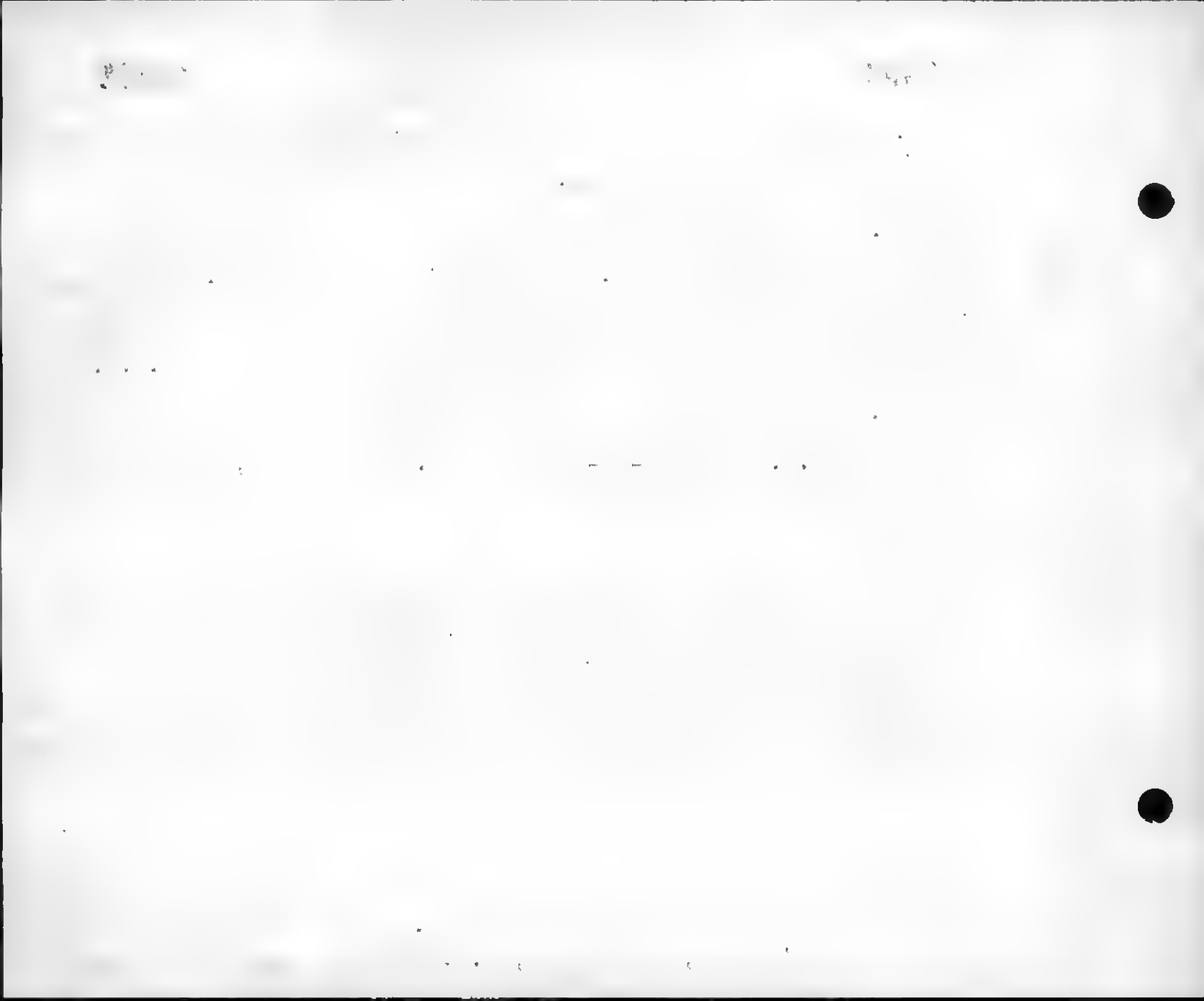
CERTIFICATE OF DEATH

14321

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7113 W. Greenvale Parkway</b>		e. STREET ADDRESS <b>7113 W. Greenvale Parkway</b>	
3 NAME OF DECEASED (Type or print) <b>JOHN H. CLAGETT, JR</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>31</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1896</b>
9. AGE (In years last birthday) <b>70 yrs</b>		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Clagett</b>		14 MOTHER'S MAIDEN NAME <b>Sophie Hohman</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W.I</b>		16. SOCIAL SECURITY NO <b>214-03-0555</b>	
17. INFORMANT <b>John H. Clagett III, Same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>4201 IMMEDIATE CAUSE (a) Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Pyelonephritis</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May, 1963</b> , to <b>10-31, 1966</b> , that (I) (we) last saw the deceased alive on <b>10-24 1966</b> , and that death occurred at <b>11:05 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles G. Smith</b>		22b. DATE SIGNED <b>11-1-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles G. Smith M.D.</b>		22d. ADDRESS <b>4615 Lee Highway Arlington, Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/3/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 7 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

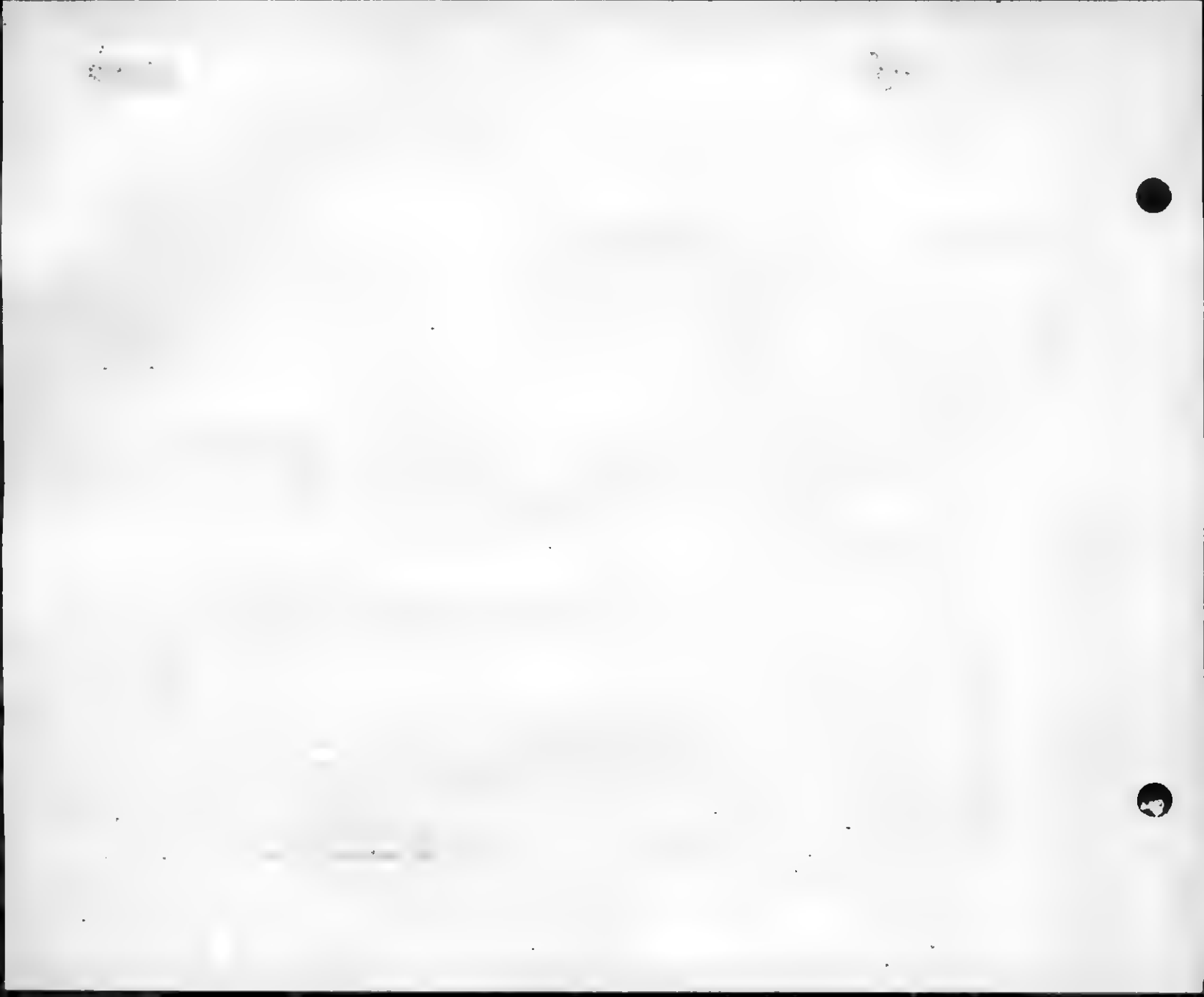
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14322

CERTIFICATE OF DEATH

14322

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
c. LENGTH OF STAY IN TB <u>36 DAYS</u>				d. STREET ADDRESS <u>10110 GEORGIA AVENUE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>W.</u> Last <u>CLARK</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>31</u> Year <u>1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-24-1887</u>	
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Stripping &amp; Screening Clark Manufacturers</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Iowa</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Iowa</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Benjamin Clark</u>				14. MOTHER'S MAIDEN NAME <u>Eva Worrell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>218-16-0111</u>		17. INFORMANT <u>Belle Clark</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral metastasis</u> DUE TO (b) <u>Cancer colon</u> stating the underlying cause lost. (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>38 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <u></u> at work <u></u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 25, 1966</u> to <u>Oct 31, 1966</u> that (I) (we) lost saw the deceased alive on <u>Oct 30, 1966</u> , and that death occurred at <u>6:30 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Edward J. Richards</u> M.D.				22b. DATE SIGNED <u>Oct 31, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>	
22d. ADDRESS <u>10110 Georgia Avenue, S. S., Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2 Nov 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>NOV 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

<div>Items 18&amp;21 Film 383 14323</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>14323 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14323</div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suburban</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>10125 Thornwood Rd</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>STEPHEN SHAWN CLARKE</u>				4. DATE OF DEATH Month Day Year <u>Oct 13 1966</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>July 21 1966</u>				9. AGE (In years last birthday) <u>—</u> yrs. <u>3</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>CHARLES CLARKE</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Eliza Boyd</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Father - same as above</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia (SDII)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22. DATE SIGNED <u>Oct. 13, 1966</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-14-66</u> 23b. DATE THEREOF <u>10-14-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>State of Md</u> 23d. LOCATION (City, town or county) (State) <u>St. Louis Mo</u>							
24. FUNERAL DIRECTOR <u>B. HANLON</u> ADDRESS <u>4748 NW 5c AVE. NW</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. DATE <u>10-15-66</u> <u>OCT 20 1966</u>			



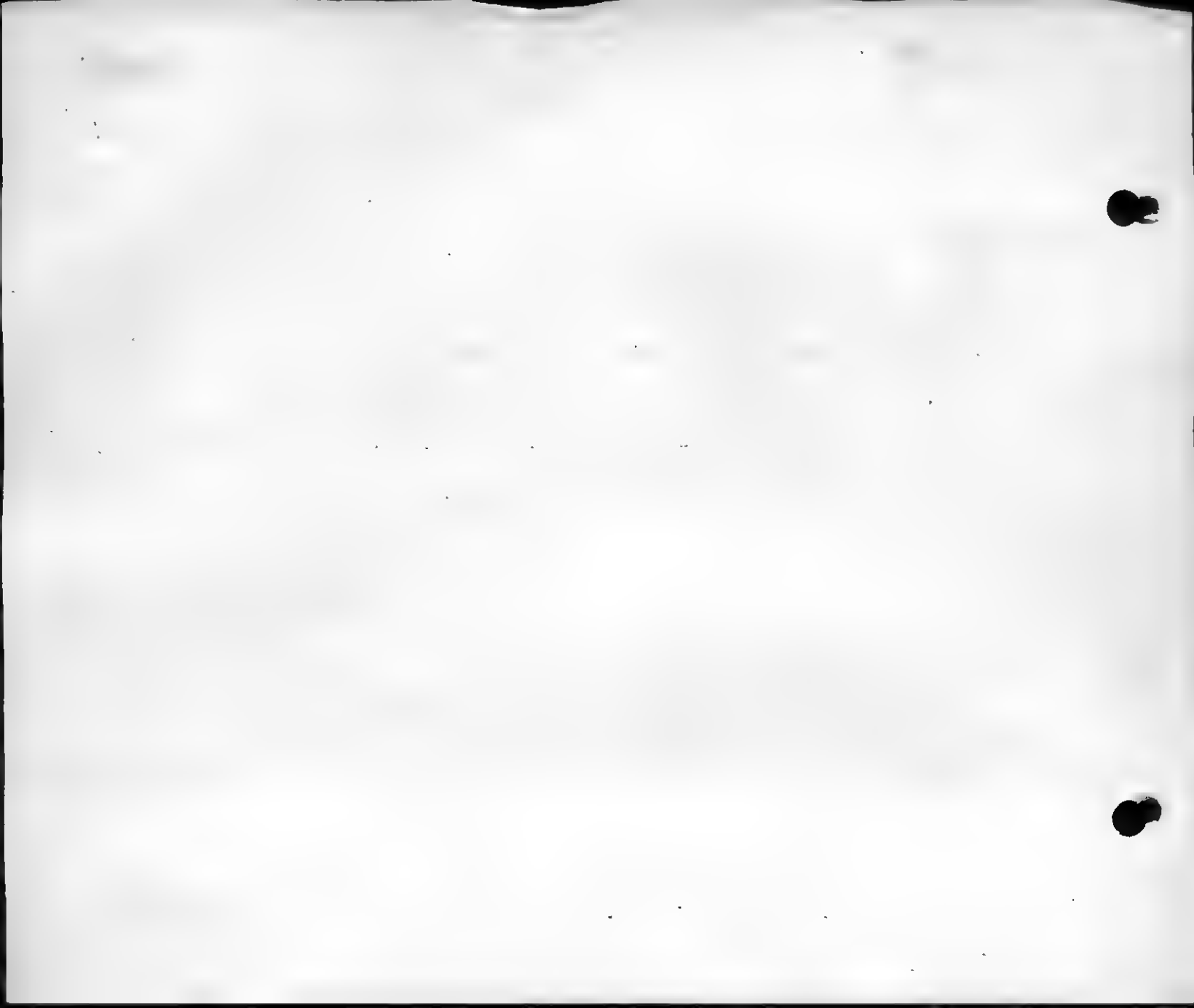
TO HOSPITAL CLERK: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
14324  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14324

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SANITARIUM AND HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. STREET ADDRESS <b>9904 CAPITOL VIEW AVE.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES ROSS CLEAVES</b>		4. DATE OF DEATH Month Day Year <b>OCT. 12 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 2, 1895</b>
9. AGE (In years lost birthday) <b>71</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Landscape Gardener</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Landscaping</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. of American</b>	
13. FATHER'S NAME <b>Mr. Iron Cleaves</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Pollard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW I Army</b>		16. SOCIAL SECURITY NO <b>577-09-1430</b>	
17. INFORMANT <b>Mrs. Leafy L. Cleaves</b>		Address <b>9904 Capitol View Ave. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA URINARY BLADDER</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PULMONARY EMPHYSEMA AND RIGHT INGUINAL HERNIA</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY EMPHYSEMA AND RIGHT INGUINAL HERNIA</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>NOV. 18, 1957</b> to <b>OCT. 12, 1966</b> that (1) (we) last saw the deceased alive on <b>OCT. 12, 1966</b> and that death occurred at <b>12:40 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James A. Roberts</b> M.D.		22b. DATE SIGNED <b>OCT. 12, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES A. ROBERTS</b>		22d. ADDRESS <b>8907 GEB. AVE. SILVER SPRING, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 15, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mt. Williams, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Glen Carter</b> <b>Warner L. Humphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>OCT 17 1966</b>	
ADDRESS <b>4434 Georgia Ave. Silver Spring, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





FOR STATE  
HEALTH DEPT.

14325

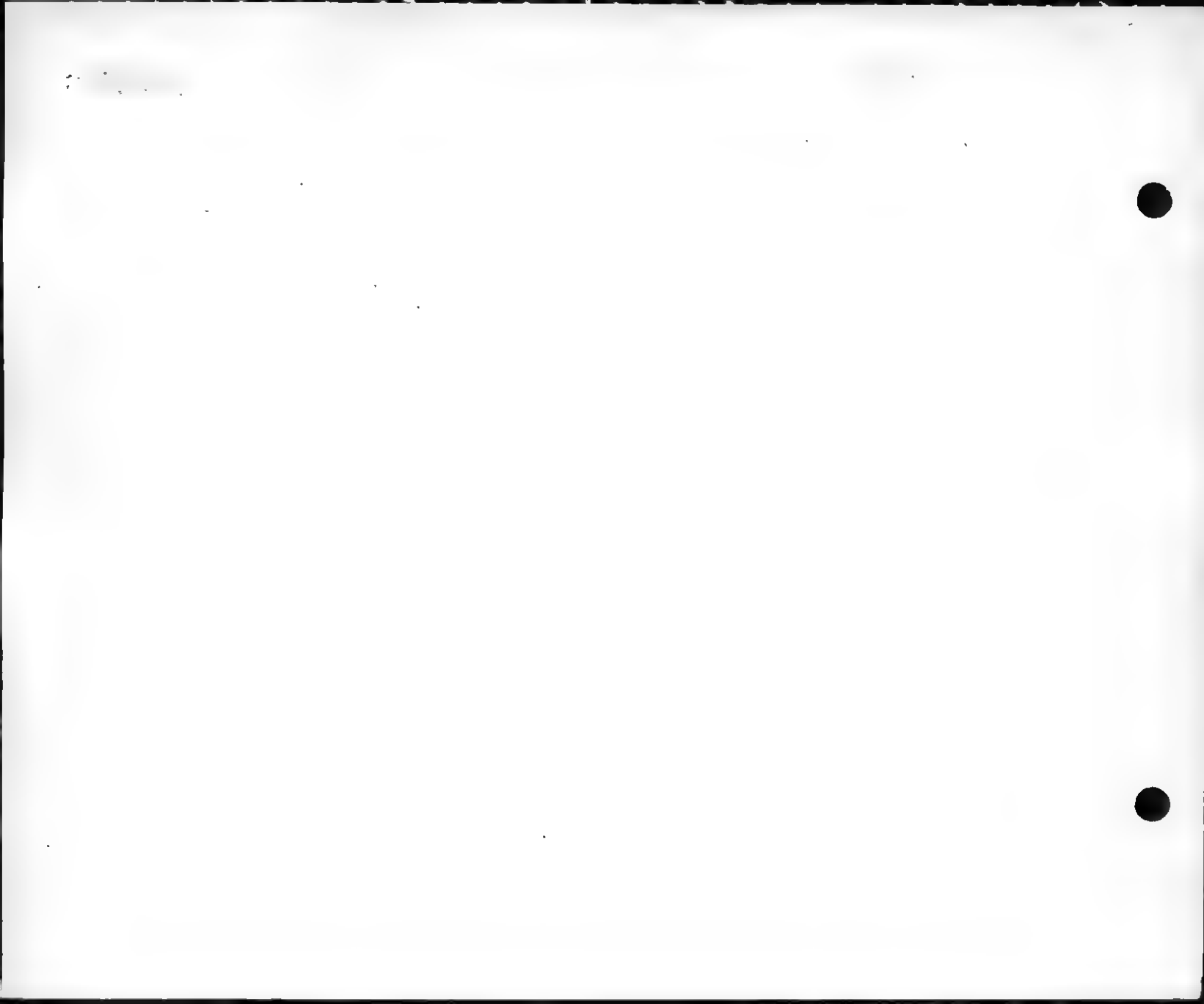
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14325

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Sant Hospital</u>		d. STREET ADDRESS <u>3009 Winifred Dr</u>	
3 NAME OF DECEASED (Type or print) <u>Ralph Eugene Cochran</u>		4 DATE OF DEATH <u>10 15 1966</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-15-32</u>
9 AGE (In years last birthday) <u>34</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Prosser, Md</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13 FATHER'S NAME <u>Ralph Eugene Cochran</u>	
14 MOTHER'S MAIDEN NAME <u>Helen Alberta Jewell</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16 SOCIAL SECURITY NO <u>218-24-2303</u>		17 INFORMANT <u>Carolyn F. Cochran Burtonsville, Md</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Massive subarachnoid Hemorrhage</u>			
DUE TO (b) <u>due to rupture of intracranial</u>			
DUE TO (c) <u>artery near Circle of Willis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town or county) <u>Oct. 16, 1966</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/18/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Prince Georges</u>
24 FUNERAL DIRECTOR <u>F. Guskie son of Hyattsville, Md</u>		25a. REC'D BY REGISTRAR <u>Oct 18 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



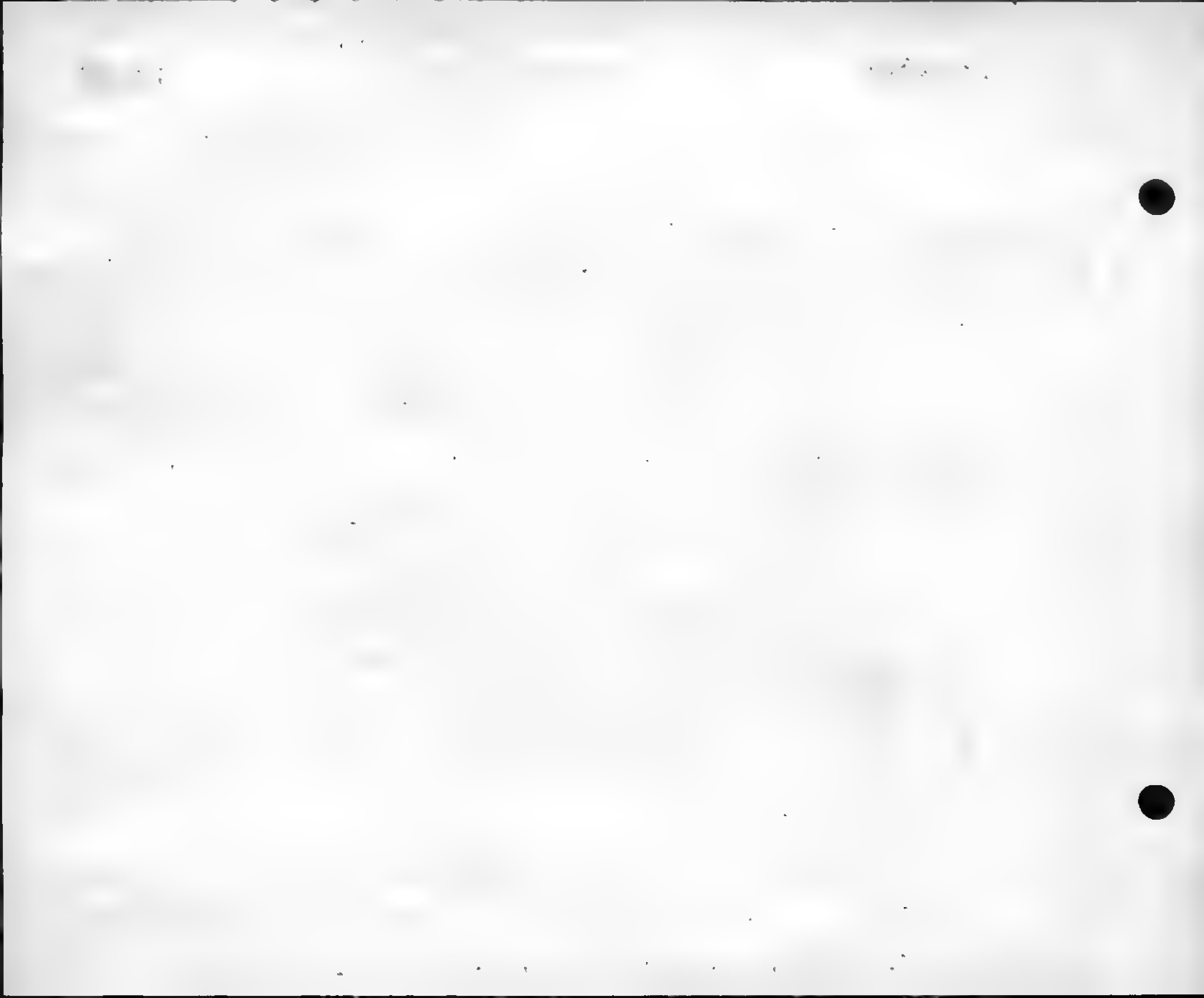
CERTIFICATE OF DEATH

14326

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>5904 Bryn Mawr Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude C. Colister</u>		4 DATE OF DEATH <u>October 17</u> 19 <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1895</u>
9. AGE (In years last birthday) <u>70 26</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Slavin</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-30-1476</u>	
17. INFORMANT <u>John R. Colister</u>		5904 Bryn Mawr Road College Park, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Insufficiency</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Decompensated Congestive Failure</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> to <u>Oct</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-17</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>10-17-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct 19, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>OCT 19 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please sign page 3 and 4, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

(M)

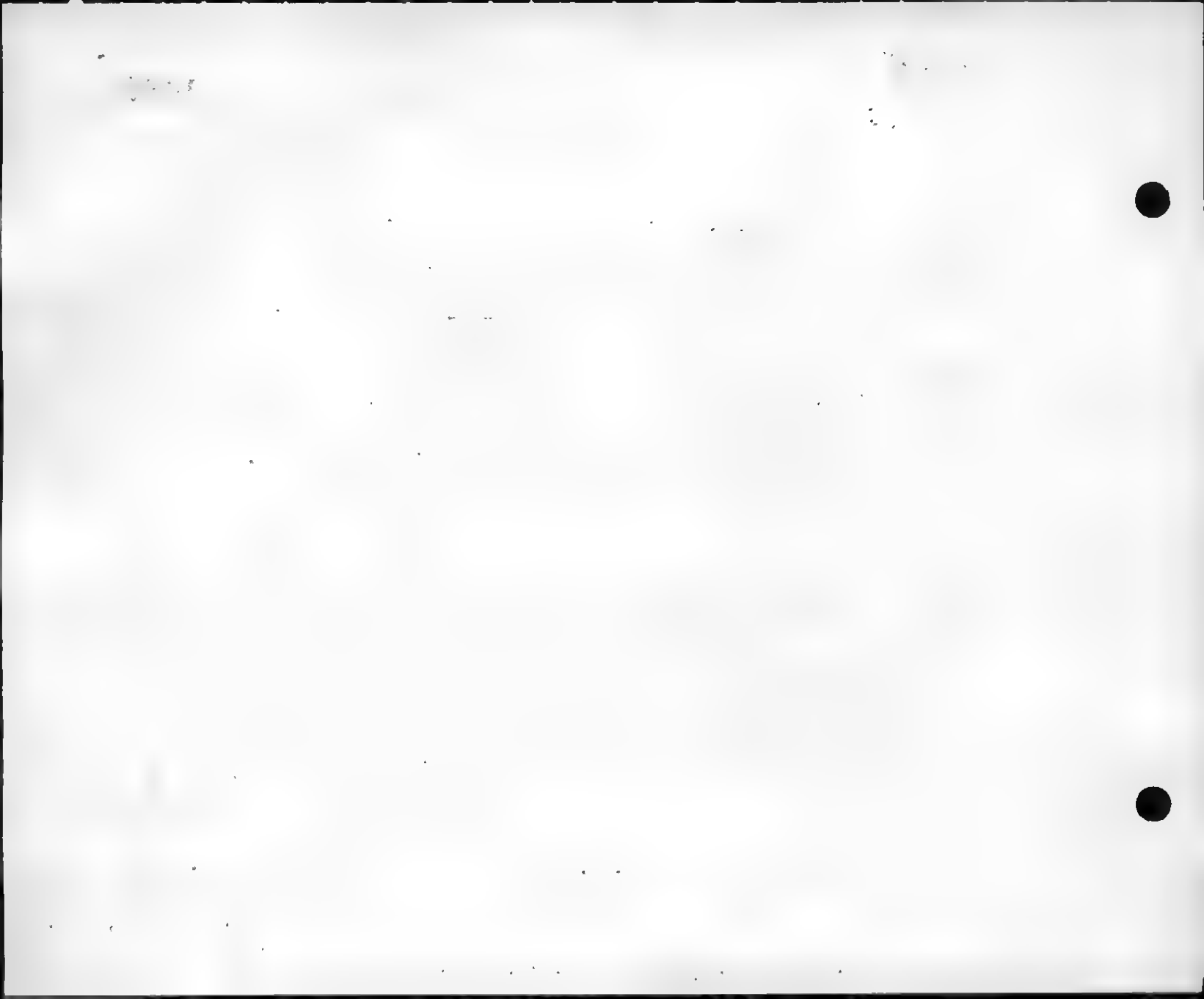
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14327

CERTIFICATE OF DEATH

14327

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>NONE</b>	
3. NAME OF DECEASED (Type or print) First <b>ELMER</b> Middle <b>EDWIN</b> Last <b>COLLINS</b>		4. DATE OF DEATH Month <b>10</b> Day <b>19</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-23-90</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER &amp; PAINTER RETIRED</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER &amp; PAINTER RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES A. COLLINS</b>		14. MOTHER'S MAIDEN NAME <b>SARAH UNGLESBEE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>214-18-8350</b>	
17. INFORMANT <b>MEDICAL RECORDS DEPT.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Rupture Lt. anterior Cerebral artery hours</b> (b) <b>Hypertensive Cardiovascular disease</b> DUE TO <b>Hypertensive Cardiovascular disease</b> (c) <b>Hypertensive Cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-19, 1966</b> , to <b>10-19, 1966</b> , that (I) (we) last saw the deceased alive on <b>10-19, 1966</b> , and that death occurred at <b>2:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Jack Schumacher</b> M.D.		22b. DATE SIGNED <b>10-20-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JACK SCHUMACHER, M. D.</b>		22d. ADDRESS <b>GAITHERSBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-22-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Neelsville</b>		23d. LOCATION (City or Town) (County) (State) <b>German town Montg Md.</b>	
24. FUNERAL DIRECTOR <b>Ernest C. Gartner</b> ADDRESS <b>Gaithersburg, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 24 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO ATTENDING MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Items 18, 21, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM-3. Page 5 may be retained for your files.

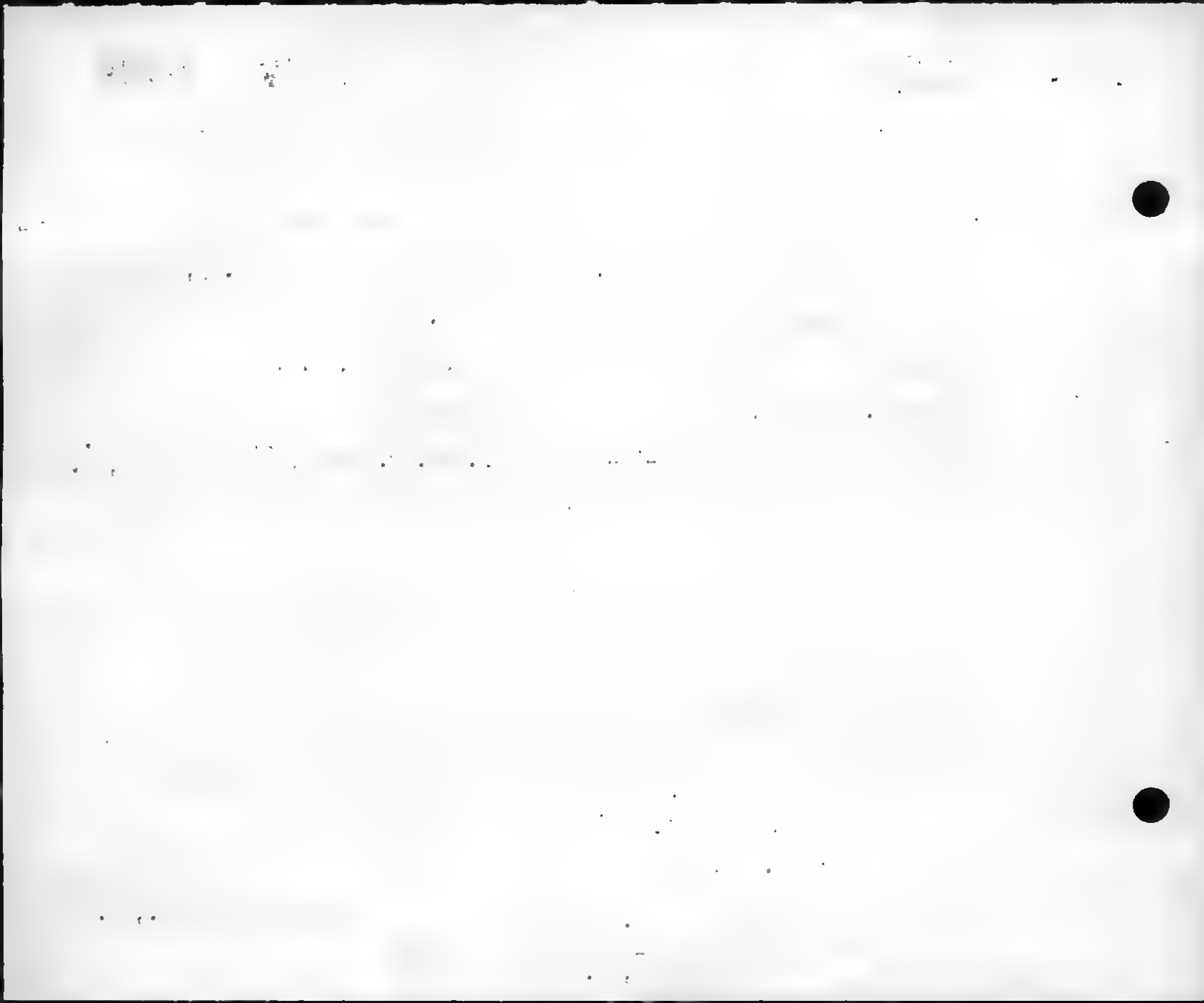
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File, pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14328

14328

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> c. LENGTH OF STAY IN 1b <b>Rockville</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6902 Tilden Lane</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>6902 Tilden Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MAUDE</b>		First <b>F.</b>		Middle <b>COLLINS</b>		Last <b>COLLINS</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 Nov. 1885</b>	
9. AGE (In years last birthday) <b>80 yrs.</b>		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>George E. Fletcher</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-46-3827</b>		17. INFORMANT <b>MGen. Wm. R. Collins</b> Address <b>4107 Dakota Ct. Alexandria, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute</b> <b>7201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cardio Vascular Disease -</b> (c) <b>Chronic</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John G. Ball</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> - 10/8/66 22. DATE SIGNED <b>10/8/66</b>			
EXAMINER'S NAME (Type) <b>John G. Ball</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/10/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Prince George Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike</b> <b>Rockville, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 11 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14329

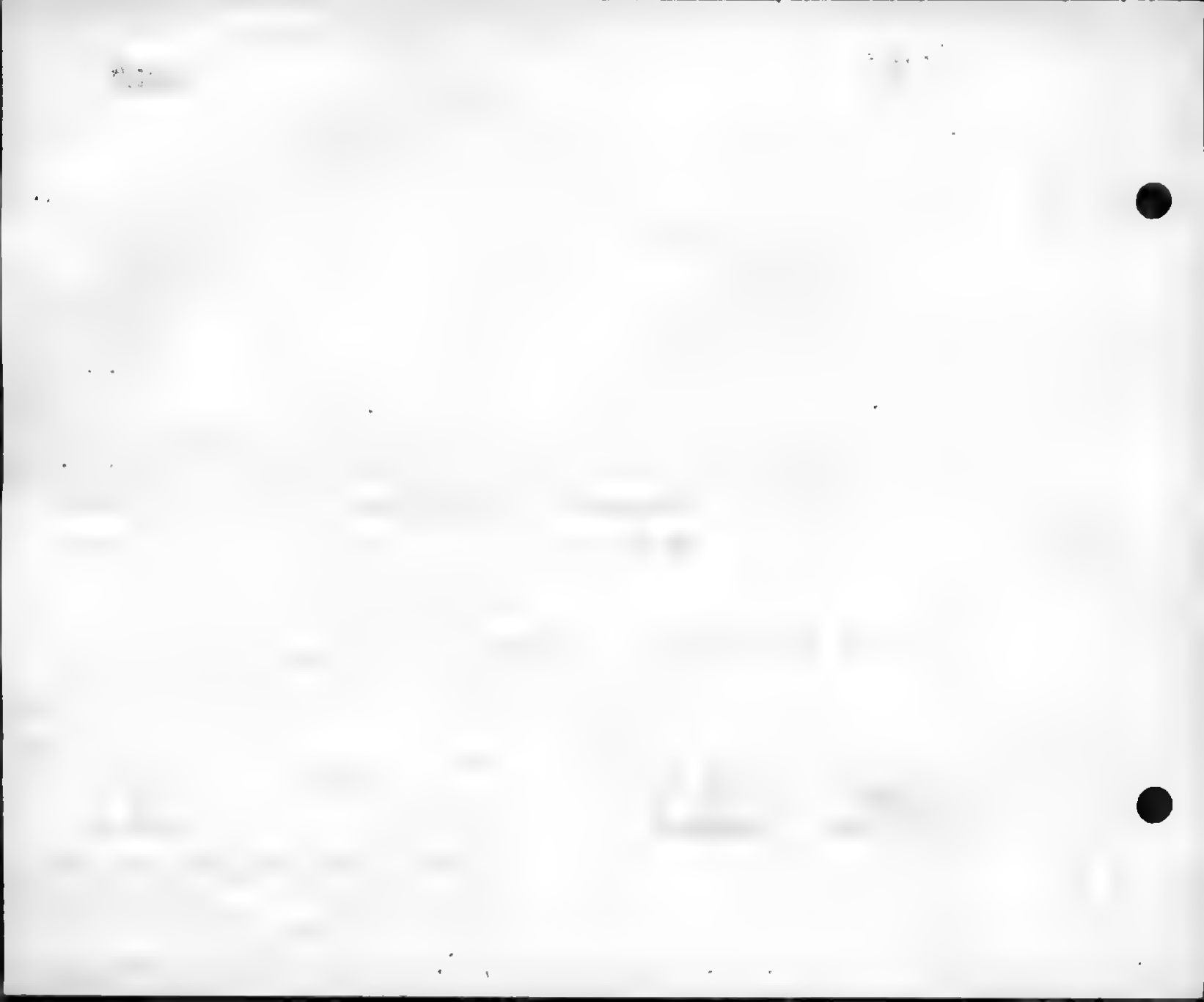
## CERTIFICATE OF DEATH

14329

1 PLACE OF DEATH a. COUNTY <u>Montgomery Co. Silver Spring</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>		d. STREET ADDRESS <u>816 Philadelphia Avenue</u>	
3 NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>A.</u> Last <u>COLLINS</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/20/85</u>
9 AGE (In years last birthday) <u>81</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11 BIRTHPLACE (County & State or foreign country) <u>Greenleaf, Kansas</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Hugh Thorman</u>	
14. MOTHER'S MAIDEN NAME <u>Amelia S. Hobby</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>570-16-6432</u>		17. INFORMANT <u>Hugh Reynolds Collins</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>ASCVD</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral atherosclerosis &amp; CVA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>Oct. 31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 26</u> , 19 <u>66</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>Man Schuch</u>		22b. DATE SIGNED <u>10/31/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John B. Thomas</u>		22d. ADDRESS <u>911 Silver Spring Ave, S.S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3 Nov 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>NOV 4 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

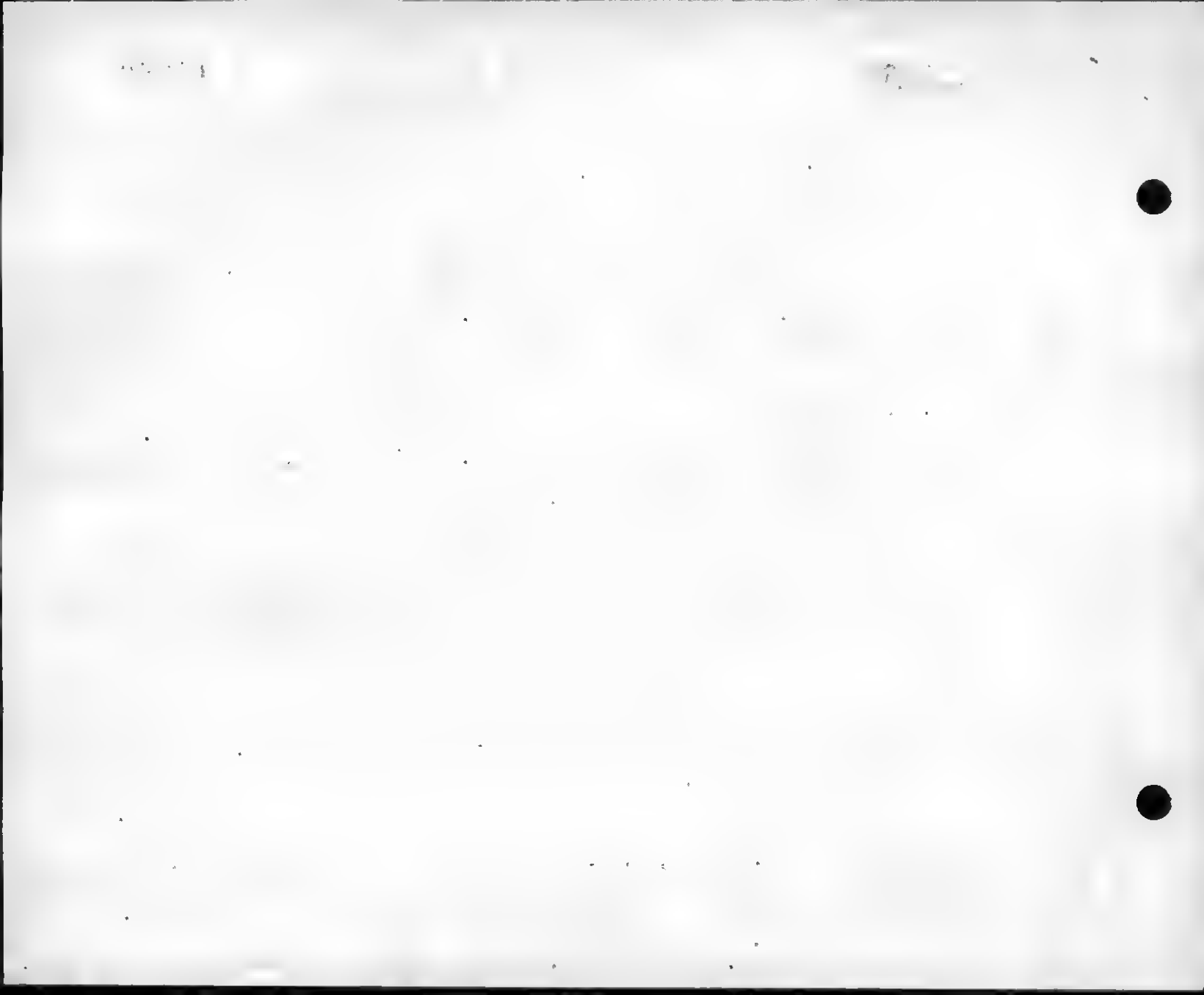
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14330

CERTIFICATE OF DEATH

14330

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>3 mos. 3 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stafford</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>Box Route 2, Box 205</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Harry</b> Last <b>Collins</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>21</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 23, 1910</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>21</b> Hours <b>19</b> Min <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USMC</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Collins Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Z. C. Collins</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes 1931-1953</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Stafford</b> <b>Mrs. Edith Collins, Route 2, Box 205</b>		Address <b>Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Hemorrhage, massive, lung</b> <b>1621</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchogenic carcinoma</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>July 18</b> , 19 <b>66</b> , to <b>Oct. 21</b> , 19 <b>66</b> , that (1) (we) last saw the deceased alive on <b>Oct. 21</b> , 19 <b>66</b> , and that death occurred at <b>730A</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>Robert J. Kinney, M.D.</b>		22b. DATE SIGNED <b>Oct. 21, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Kinney, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-24-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Fredricksburg, Va.</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> <b>7557 Wisconsin Ave., Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 25 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

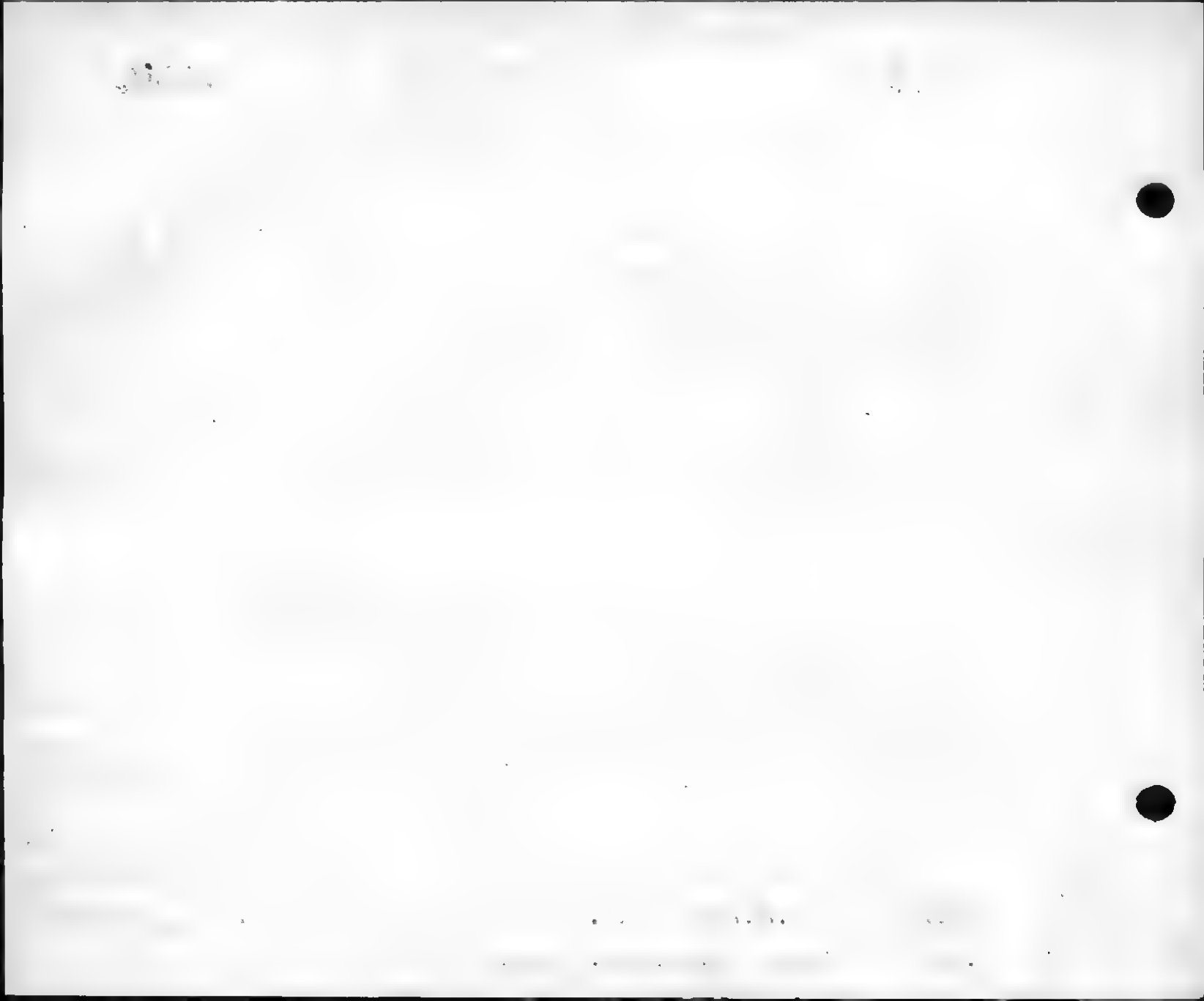
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14331

CERTIFICATE OF DEATH

14331

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>2 days</i>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Dist. of Columbia</i> b. COUNTY <i>Washington</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> d. STREET ADDRESS <i>614 Ridge Rd. S.E.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>Joseph Norman Colton</i>		4. DATE OF DEATH Month Day Year <i>Oct 7 1966</i>	
5 SEX <i>Male</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>1-14-92</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Civil Service</i>		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>
12 CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Frank Johnson Colton</i>	
14. MOTHER'S MAIDEN NAME <i>Marie P. Delahay</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give War or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT <i>Hospital Records</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>1621</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>bronchogenic carcinoma</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>more than 6 months</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 20</i> , 19 <i>66</i> to <i>Oct. 7</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Oct. 7</i> , 19 <i>66</i> , and that death occurred at <i>7:30</i> M, from causes and on the date stated above.			
22a SIGNATURE <i>Charles H. Kappas</i>		22b. DATE SIGNED <i>Oct. 7, 1966</i>	
22c PHYSICIAN'S NAME (Type) <i>Charles H. Kappas MD</i>		22d ADDRESS <i>Washington, D.C.</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE THEREOF <i>Oct. 10, 1966</i>	23c NAME OF CEMETERY OR CREMATORY <i>St. Josephs</i>	23d. LOCATION (City or Town) (County) (State) <i>Morganza Maryland</i>
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley Leonardtown, Maryland</i>		25a REC'D BY REGISTRAR <i>Charles Judge</i>	
25b REGISTRAR'S SIGNATURE		DATE <i>OCT 11 1966</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

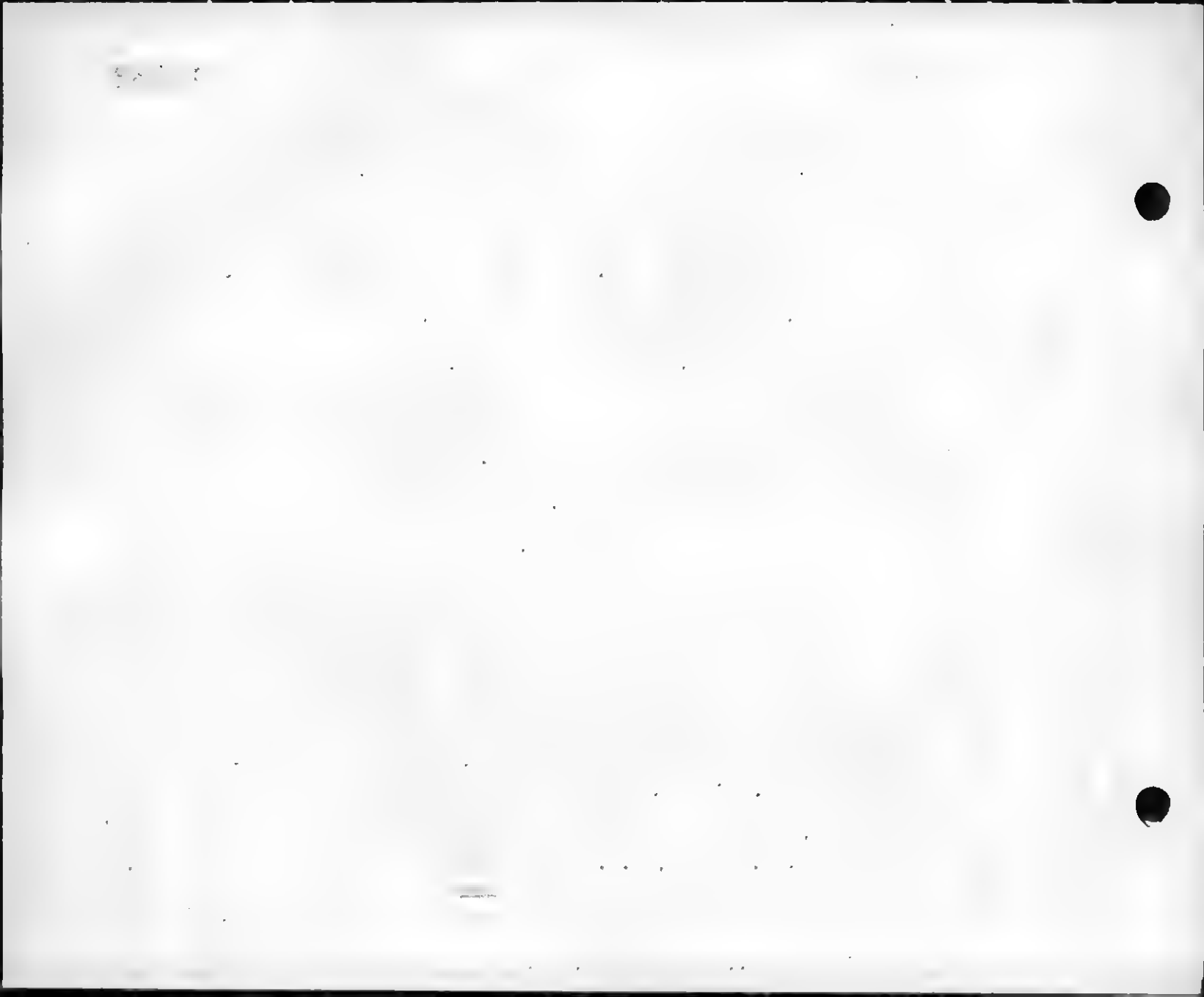
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14332

CERTIFICATE OF DEATH

14332

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>81 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
3. NAME OF DECEASED (Type or print) <b>Walter E. CROLL</b>		4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1892</b>
9. AGE (In years last birthday) yrs <b>74</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Musican</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Croll</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Mumie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hyattsville</b> Address <b>Maryland</b> <b>Mrs. Charlotte Croll, 7603 Inwood Street</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <del>Heart Failure</del> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Pulmonary Emphysema</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac Vascular Accident</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if this hospital) attended the deceased from <b>July 22</b> , 19 <b>66</b> , to <b>Oct. 11</b> , 19 <b>66</b> that (1) (we) last saw the deceased alive on <b>Oct. 11</b> , 19 <b>66</b> , and that death occurred at <b>220AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <i>Francis Gasch</i>		22b. DATE SIGNED <b>11 Oct. 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. J. KINNEY, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/13/66</b>	23c. NAME OF CEMETERY OR <del>CHURCH</del> <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b> ADDRESS <b>4739 Baltimore Ave., Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 17 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>





FOR STATE  
HEALTH DEPT.

TO DEPUTY MED. EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film 384 1-10-67 gsa

MARYLAND STATE DEPARTMENT OF HEALTH

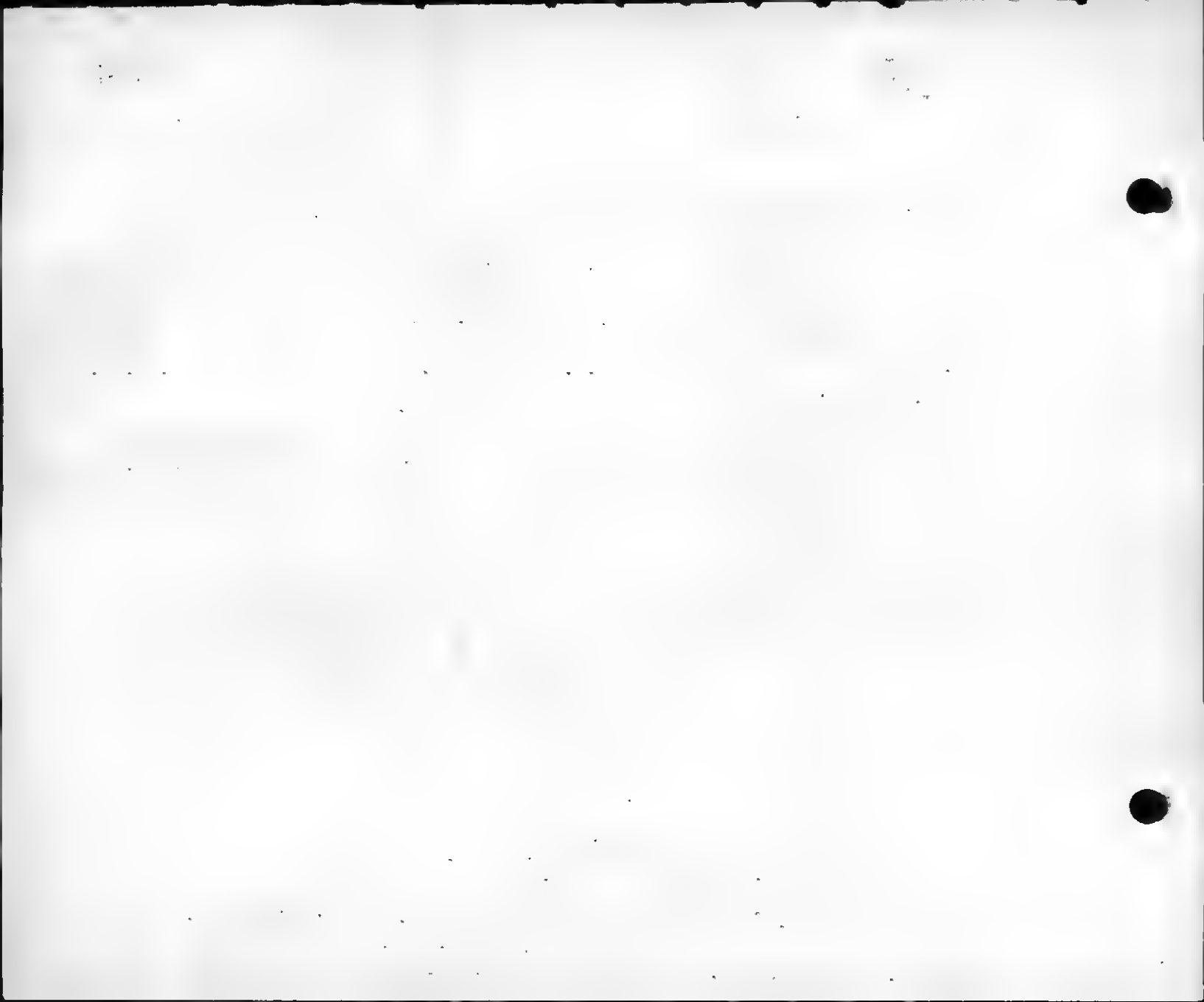
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14333

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14333

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>60 days</u>		d. STREET ADDRESS <u>9315 Weaver Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Marietta</u> Last <u>Curtiss</u>		4. DATE DEATH <u>October 31 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1883</u>
9. AGE (In years last birthday) <u>83 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Typist U.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>(Unknown) Parsons</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>217-52-6437</u>	
17. INFORMANT <u>Dwight Curtiss</u>		Address <u>9315 Weaver Street Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute massive pulmonary embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Belden R. Reap Wheaton, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <u>Nov. 2, 1966</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 3, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Nov 4 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 7, 13, 23c Film G382 11/15/66 mh

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14334

14334

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and page 4 event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY N 1b <b>SPRING</b>		2. USUAL RESIDENCE (Where deceased lived, f. institution Residence before admission) a. STATE <b>OHIO</b> b. COUNTY <b>HAMILTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NORWOOD</b> d. STREET ADDRESS <b>2302 NORWOOD AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LORETTA FAY DENMAN</b>		4. DATE OF DEATH Month Day Year <b>10 - 16 1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-29-86</b>
9. AGE (In years last birthday) yrs <b>80</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>80</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eli Carleton</b>		14. MOTHER'S MAIDEN NAME <b>Anetta Means</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>301-05-6355</b>	
17. INFORMANT <b>MRS. ELSIE SOMMER, dght. 14312 Oakvale St.</b>		Address <b>Rockville</b>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) DUE TO (d) DUE TO (e) DUE TO (f) DUE TO (g) DUE TO (h) DUE TO (i) DUE TO (j) DUE TO (k) DUE TO (l) DUE TO (m) DUE TO (n) DUE TO (o) DUE TO (p) DUE TO (q) DUE TO (r) DUE TO (s) DUE TO (t) DUE TO (u) DUE TO (v) DUE TO (w) DUE TO (x) DUE TO (y) DUE TO (z) DUE TO (aa) DUE TO (ab) DUE TO (ac) DUE TO (ad) DUE TO (ae) DUE TO (af) DUE TO (ag) DUE TO (ah) DUE TO (ai) DUE TO (aj) DUE TO (ak) DUE TO (al) DUE TO (am) DUE TO (an) DUE TO (ao) DUE TO (ap) DUE TO (aq) DUE TO (ar) DUE TO (as) DUE TO (at) DUE TO (au) DUE TO (av) DUE TO (aw) DUE TO (ax) DUE TO (ay) DUE TO (az) DUE TO (ba) DUE TO (bb) DUE TO (bc) DUE TO (bd) DUE TO (be) DUE TO (bf) DUE TO (bg) DUE TO (bh) DUE TO (bi) DUE TO (bj) DUE TO (bk) DUE TO (bl) DUE TO (bm) DUE TO (bn) DUE TO (bo) DUE TO (bp) DUE TO (bq) DUE TO (br) DUE TO (bs) DUE TO (bt) DUE TO (bu) DUE TO (bv) DUE TO (bw) DUE TO (bx) DUE TO (by) DUE TO (bz) DUE TO (ca) DUE TO (cb) DUE TO (cc) DUE TO (cd) DUE TO (ce) DUE TO (cf) DUE TO (cg) DUE TO (ch) DUE TO (ci) DUE TO (cj) DUE TO (ck) DUE TO (cl) DUE TO (cm) DUE TO (cn) DUE TO (co) DUE TO (cp) DUE TO (cq) DUE TO (cr) DUE TO (cs) DUE TO (ct) DUE TO (cu) DUE TO (cv) DUE TO (cw) DUE TO (cx) DUE TO (cy) DUE TO (cz) DUE TO (da) DUE TO (db) DUE TO (dc) DUE TO (dd) DUE TO (de) DUE TO (df) DUE TO (dg) DUE TO (dh) DUE TO (di) DUE TO (dj) DUE TO (dk) DUE TO (dl) DUE TO (dm) DUE TO (dn) DUE TO (do) DUE TO (dp) DUE TO (dq) DUE TO (dr) DUE TO (ds) DUE TO (dt) DUE TO (du) DUE TO (dv) DUE TO (dw) DUE TO (dx) DUE TO (dy) DUE TO (dz) DUE TO (ea) DUE TO (eb) DUE TO (ec) DUE TO (ed) DUE TO (ee) DUE TO (ef) DUE TO (eg) DUE TO (eh) DUE TO (ei) DUE TO (ej) DUE TO (ek) DUE TO (el) DUE TO (em) DUE TO (en) DUE TO (eo) DUE TO (ep) DUE TO (eq) DUE TO (er) DUE TO (es) DUE TO (et) DUE TO (eu) DUE TO (ev) DUE TO (ew) DUE TO (ex) DUE TO (ey) DUE TO (ez) DUE TO (fa) DUE TO (fb) DUE TO (fc) DUE TO (fd) DUE TO (fe) DUE TO (ff) DUE TO (fg) DUE TO (fh) DUE TO (fi) DUE TO (fj) DUE TO (fk) DUE TO (fl) DUE TO (fm) DUE TO (fn) DUE TO (fo) DUE TO (fp) DUE TO (fq) DUE TO (fr) DUE TO (fs) DUE TO (ft) DUE TO (fu) DUE TO (fv) DUE TO (fw) DUE TO (fx) DUE TO (fy) DUE TO (fz) DUE TO (ga) DUE TO (gb) DUE TO (gc) DUE TO (gd) DUE TO (ge) DUE TO (gf) DUE TO (gg) DUE TO (gh) DUE TO (gi) DUE TO (gj) DUE TO (gk) DUE TO (gl) DUE TO (gm) DUE TO (gn) DUE TO (go) DUE TO (gp) DUE TO (gq) DUE TO (gr) DUE TO (gs) DUE TO (gt) DUE TO (gu) DUE TO (gv) DUE TO (gw) DUE TO (gx) DUE TO (gy) DUE TO (gz) DUE TO (ha) DUE TO (hb) DUE TO (hc) DUE TO (hd) DUE TO (he) DUE TO (hf) DUE TO (hg) DUE TO (hh) DUE TO (hi) DUE TO (hj) DUE TO (hk) DUE TO (hl) DUE TO (hm) DUE TO (hn) DUE TO (ho) DUE TO (hp) DUE TO (hq) DUE TO (hr) DUE TO (hs) DUE TO (ht) DUE TO (hu) DUE TO (hv) DUE TO (hw) DUE TO (hx) DUE TO (hy) DUE TO (hz) DUE TO (ia) DUE TO (ib) DUE TO (ic) DUE TO (id) DUE TO (ie) DUE TO (if) DUE TO (ig) DUE TO (ih) DUE TO (ii) DUE TO (ij) DUE TO (ik) DUE TO (il) DUE TO (im) DUE TO (in) DUE TO (io) DUE TO (ip) DUE TO (iq) DUE TO (ir) DUE TO (is) DUE TO (it) DUE TO (iu) DUE TO (iv) DUE TO (iw) DUE TO (ix) DUE TO (iy) DUE TO (iz) DUE TO (ja) DUE TO (jb) DUE TO (jc) DUE TO (jd) DUE TO (je) DUE TO (jf) DUE TO (jg) DUE TO (jh) DUE TO (ji) DUE TO (jj) DUE TO (jk) DUE TO (jl) DUE TO (jm) DUE TO (jn) DUE TO (jo) DUE TO (jp) DUE TO (jq) DUE TO (jr) DUE TO (js) DUE TO (jt) DUE TO (ju) DUE TO (jv) DUE TO (jw) DUE TO (jx) DUE TO (jy) DUE TO (jz) DUE TO (ka) DUE TO (kb) DUE TO (kc) DUE TO (kd) DUE TO (ke) DUE TO (kf) DUE TO (kg) DUE TO (kh) DUE TO (ki) DUE TO (kj) DUE TO (kk) DUE TO (kl) DUE TO (km) DUE TO (kn) DUE TO (ko) DUE TO (kp) DUE TO (kq) DUE TO (kr) DUE TO (ks) DUE TO (kt) DUE TO (ku) DUE TO (kv) DUE TO (kw) DUE TO (kx) DUE TO (ky) DUE TO (kz) DUE TO (la) DUE TO (lb) DUE TO (lc) DUE TO (ld) DUE TO (le) DUE TO (lf) DUE TO (lg) DUE TO (lh) DUE TO (li) DUE TO (lj) DUE TO (lk) DUE TO (ll) DUE TO (lm) DUE TO (ln) DUE TO (lo) DUE TO (lp) DUE TO (lq) DUE TO (lr) DUE TO (ls) DUE TO (lt) DUE TO (lu) DUE TO (lv) DUE TO (lw) DUE TO (lx) DUE TO (ly) DUE TO (lz) DUE TO (ma) DUE TO (mb) DUE TO (mc) DUE TO (md) DUE TO (me) DUE TO (mf) DUE TO (mg) DUE TO (mh) DUE TO (mi) DUE TO (mj) DUE TO (mk) DUE TO (ml) DUE TO (mm) DUE TO (mn) DUE TO (mo) DUE TO (mp) DUE TO (mq) DUE TO (mr) DUE TO (ms) DUE TO (mt) DUE TO (mu) DUE TO (mv) DUE TO (mw) DUE TO (mx) DUE TO (my) DUE TO (mz) DUE TO (na) DUE TO (nb) DUE TO (nc) DUE TO (nd) DUE TO (ne) DUE TO (nf) DUE TO (ng) DUE TO (nh) DUE TO (ni) DUE TO (nj) DUE TO (nk) DUE TO (nl) DUE TO (nm) DUE TO (nn) DUE TO (no) DUE TO (np) DUE TO (nq) DUE TO (nr) DUE TO (ns) DUE TO (nt) DUE TO (nu) DUE TO (nv) DUE TO (nw) DUE TO (nx) DUE TO (ny) DUE TO (nz) DUE TO (oa) DUE TO (ob) DUE TO (oc) DUE TO (od) DUE TO (oe) DUE TO (of) DUE TO (og) DUE TO (oh) DUE TO (oi) DUE TO (oj) DUE TO (ok) DUE TO (ol) DUE TO (om) DUE TO (on) DUE TO (oo) DUE TO (op) DUE TO (oq) DUE TO (or) DUE TO (os) DUE TO (ot) DUE TO (ou) DUE TO (ov) DUE TO (ow) DUE TO (ox) DUE TO (oy) DUE TO (oz) DUE TO (pa) DUE TO (pb) DUE TO (pc) DUE TO (pd) DUE TO (pe) DUE TO (pf) DUE TO (pg) DUE TO (ph) DUE TO (pi) DUE TO (pj) DUE TO (pk) DUE TO (pl) DUE TO (pm) DUE TO (pn) DUE TO (po) DUE TO (pp) DUE TO (pq) DUE TO (pr) DUE TO (ps) DUE TO (pt) DUE TO (pu) DUE TO (pv) DUE TO (pw) DUE TO (px) DUE TO (py) DUE TO (pz) DUE TO (qa) DUE TO (qb) DUE TO (qc) DUE TO (qd) DUE TO (qe) DUE TO (qf) DUE TO (qg) DUE TO (qh) DUE TO (qi) DUE TO (qj) DUE TO (qk) DUE TO (ql) DUE TO (qm) DUE TO (qn) DUE TO (qo) DUE TO (qp) DUE TO (qq) DUE TO (qr) DUE TO (qs) DUE TO (qt) DUE TO (qu) DUE TO (qv) DUE TO (qw) DUE TO (qx) DUE TO (qy) DUE TO (qz) DUE TO (ra) DUE TO (rb) DUE TO (rc) DUE TO (rd) DUE TO (re) DUE TO (rf) DUE TO (rg) DUE TO (rh) DUE TO (ri) DUE TO (rj) DUE TO (rk) DUE TO (rl) DUE TO (rm) DUE TO (rn) DUE TO (ro) DUE TO (rp) DUE TO (rq) DUE TO (rr) DUE TO (rs) DUE TO (rt) DUE TO (ru) DUE TO (rv) DUE TO (rw) DUE TO (rx) DUE TO (ry) DUE TO (rz) DUE TO (sa) DUE TO (sb) DUE TO (sc) DUE TO (sd) DUE TO (se) DUE TO (sf) DUE TO (sg) DUE TO (sh) DUE TO (si) DUE TO (sj) DUE TO (sk) DUE TO (sl) DUE TO (sm) DUE TO (sn) DUE TO (so) DUE TO (sp) DUE TO (sq) DUE TO (sr) DUE TO (ss) DUE TO (st) DUE TO (su) DUE TO (sv) DUE TO (sw) DUE TO (sx) DUE TO (sy) DUE TO (sz) DUE TO (ta) DUE TO (tb) DUE TO (tc) DUE TO (td) DUE TO (te) DUE TO (tf) DUE TO (tg) DUE TO (th) DUE TO (ti) DUE TO (tj) DUE TO (tk) DUE TO (tl) DUE TO (tm) DUE TO (tn) DUE TO (to) DUE TO (tp) DUE TO (tq) DUE TO (tr) DUE TO (ts) DUE TO (tt) DUE TO (tu) DUE TO (tv) DUE TO (tw) DUE TO (tx) DUE TO (ty) DUE TO (tz) DUE TO (ua) DUE TO (ub) DUE TO (uc) DUE TO (ud) DUE TO (ue) DUE TO (uf) DUE TO (ug) DUE TO (uh) DUE TO (ui) DUE TO (uj) DUE TO (uk) DUE TO (ul) DUE TO (um) DUE TO (un) DUE TO (uo) DUE TO (up) DUE TO (uq) DUE TO (ur) DUE TO (us) DUE TO (ut) DUE TO (uu) DUE TO (uv) DUE TO (uw) DUE TO (ux) DUE TO (uy) DUE TO (uz) DUE TO (va) DUE TO (vb) DUE TO (vc) DUE TO (vd) DUE TO (ve) DUE TO (vf) DUE TO (vg) DUE TO (vh) DUE TO (vi) DUE TO (vj) DUE TO (vk) DUE TO (vl) DUE TO (vm) DUE TO (vn) DUE TO (vo) DUE TO (vp) DUE TO (vq) DUE TO (vr) DUE TO (vs) DUE TO (vt) DUE TO (vu) DUE TO (vv) DUE TO (vw) DUE TO (vx) DUE TO (vy) DUE TO (vz) DUE TO (wa) DUE TO (wb) DUE TO (wc) DUE TO (wd) DUE TO (we) DUE TO (wf) DUE TO (wg) DUE TO (wh) DUE TO (wi) DUE TO (wj) DUE TO (wk) DUE TO (wl) DUE TO (wm) DUE TO (wn) DUE TO (wo) DUE TO (wp) DUE TO (wq) DUE TO (wr) DUE TO (ws) DUE TO (wt) DUE TO (wu) DUE TO (wv) DUE TO (ww) DUE TO (wx) DUE TO (wy) DUE TO (wz) DUE TO (xa) DUE TO (xb) DUE TO (xc) DUE TO (xd) DUE TO (xe) DUE TO (xf) DUE TO (xg) DUE TO (xh) DUE TO (xi) DUE TO (xj) DUE TO (xk) DUE TO (xl) DUE TO (xm) DUE TO (xn) DUE TO (xo) DUE TO (xp) DUE TO (xq) DUE TO (xr) DUE TO (xs) DUE TO (xt) DUE TO (xu) DUE TO (xv) DUE TO (xw) DUE TO (xx) DUE TO (xy) DUE TO (xz) DUE TO (ya) DUE TO (yb) DUE TO (yc) DUE TO (yd) DUE TO (ye) DUE TO (yf) DUE TO (yg) DUE TO (yh) DUE TO (yi) DUE TO (yj) DUE TO (yk) DUE TO (yl) DUE TO (ym) DUE TO (yn) DUE TO (yo) DUE TO (yp) DUE TO (yq) DUE TO (yr) DUE TO (ys) DUE TO (yt) DUE TO (yu) DUE TO (yv) DUE TO (yw) DUE TO (yx) DUE TO (yz) DUE TO (za) DUE TO (zb) DUE TO (zc) DUE TO (zd) DUE TO (ze) DUE TO (zf) DUE TO (zg) DUE TO (zh) DUE TO (zi) DUE TO (zj) DUE TO (zk) DUE TO (zl) DUE TO (zm) DUE TO (zn) DUE TO (zo) DUE TO (zp) DUE TO (zq) DUE TO (zr) DUE TO (zs) DUE TO (zt) DUE TO (zu) DUE TO (zv) DUE TO (zw) DUE TO (zx) DUE TO (zy) DUE TO (zz)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Read</b> EXAMINER'S NAME (Type) <b>BELDEN R. READ M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Oct. 16, 1966</b>	
23a. BURIAL, CREMATION, REMOVAL, or TRANSIT <b>Burial</b>		23b. DATE THEREOF <b>10/19/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Beth Haven Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cincinnati, Ohio</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 18 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10. 1. 1.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

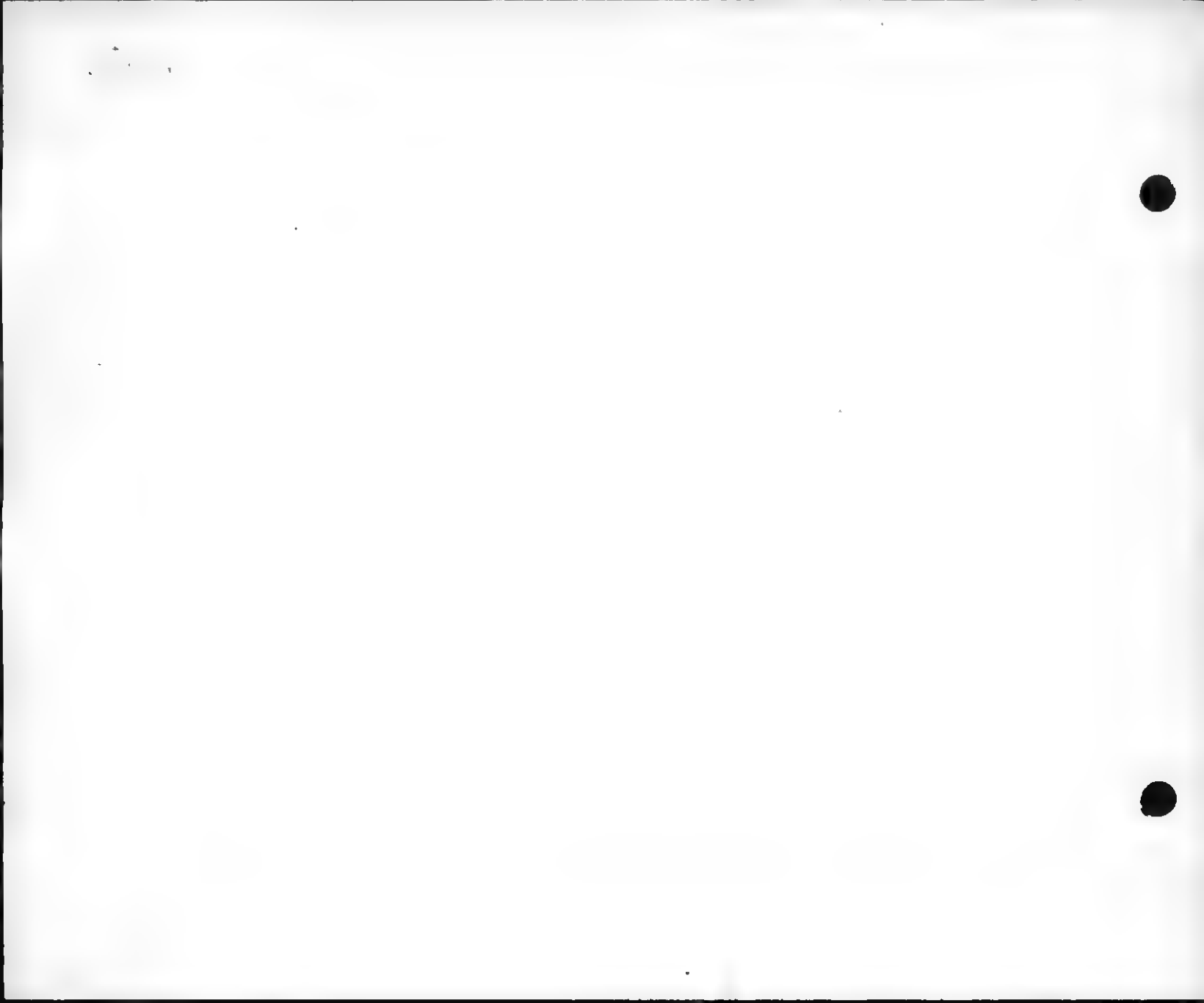
Items 18&21 Film 382 11-14-66 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14335

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14335

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY in 1b <b>4 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hospital</b>				d. STREET ADDRESS <b>1610 Drexel St.</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>B.</b> Last <b>Dierks</b>				4. DATE OF DEATH Month <b>October</b> Day <b>4</b> Year <b>19 66</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/7/61</b>	9. AGE (in years last birthday) <b>5</b> yrs	F UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min <b>10</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILDO</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Max M. Dierks</b>				14. MOTHER'S MAIDEN NAME <b>Janet Reid Vivian Jones</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSP. RECORDS</b>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest,</b> <b>4.05.01</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>unknown etiology</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b>		EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>		22. DATE SIGNED <b>Oct. 5, 1966</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct 10, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Charles Judge</b>		ADDRESS <b>WASH DC</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
				DATE <b>OCT 10 1966</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

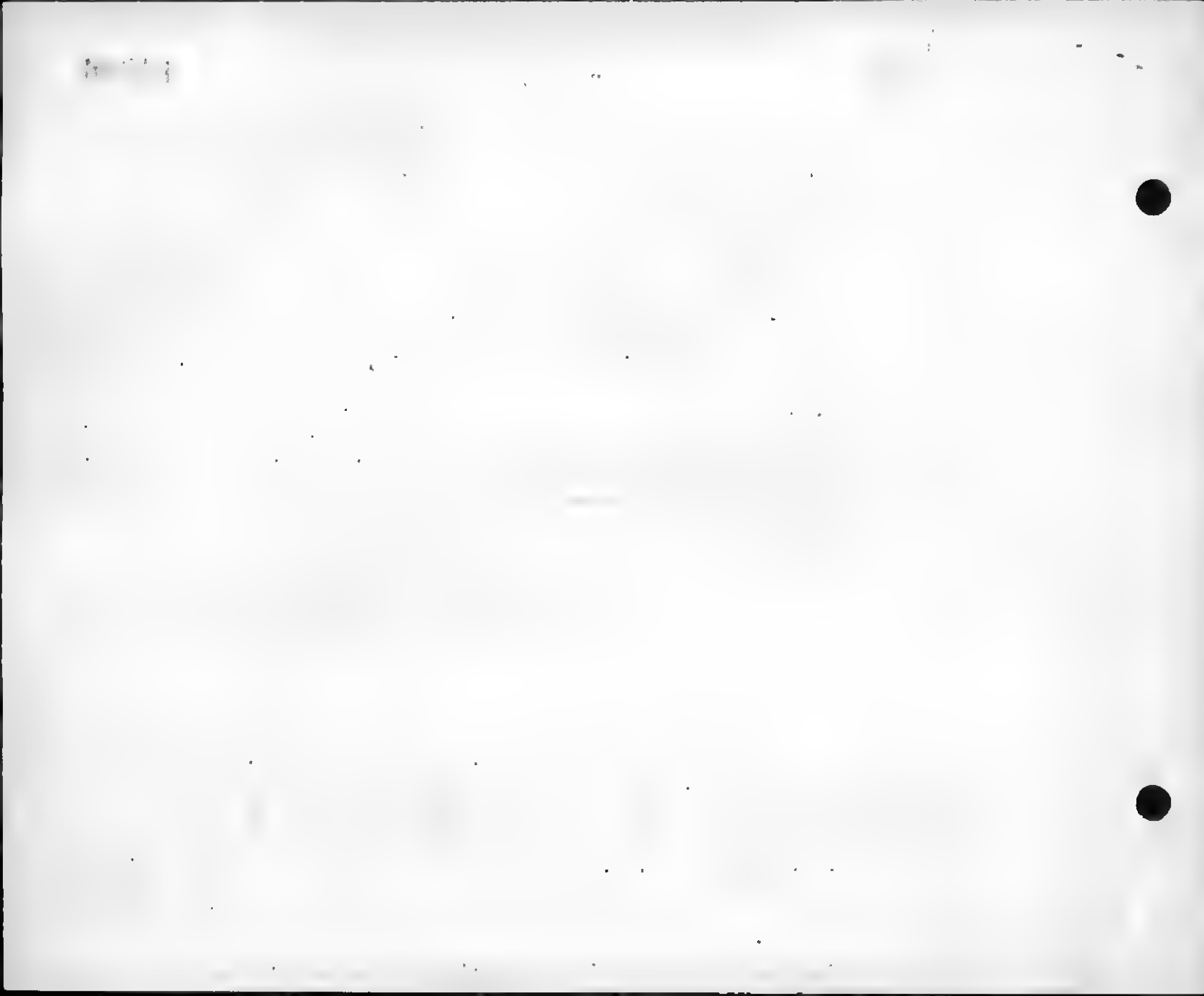
14336

## CERTIFICATE OF DEATH

14336

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 hour</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>10009 Hurst Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>DOLAN</b>			4. DATE OF DEATH Month <b>October</b> Day <b>9</b> Year <b>19 66</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1966</b>	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days Hours Min <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Bethesda, Montgomery, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Michael F. Dolan</b>			14. MOTHER'S MAIDEN NAME <b>Loretta Ann Young</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	17. INFORMANT <b>Bethesda,</b> Address <b>Maryland</b> <b>Dr. Michael F. Dolan, 10009 Hurst St.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gross immaturity</b> <b>776x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <del>(he)</del> (this hospital) attended the deceased from <b>Oct. 9</b> , 19 <b>66</b> , to <b>Oct. 9</b> , 19 <b>66</b> , that <del>(he)</del> (we) last saw the deceased alive on <b>Oct. 9</b> , 19 <b>66</b> , and that death occurred on <b>1010 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>A. E. Tompkins</i>			22b. DATE SIGNED <b>Oct. 12, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>A. E. Tompkins, M. D.</b>			22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>10-12-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>New York City, New York</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> ADDRESS <b>Funeral Home, 7557 Wisconsin Ave., Bethesda,</b>			25a. REC'D BY REGISTRAR DATE <b>OCT 13 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~page 3~~ remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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VR A15 (4)  
20 M 1/66

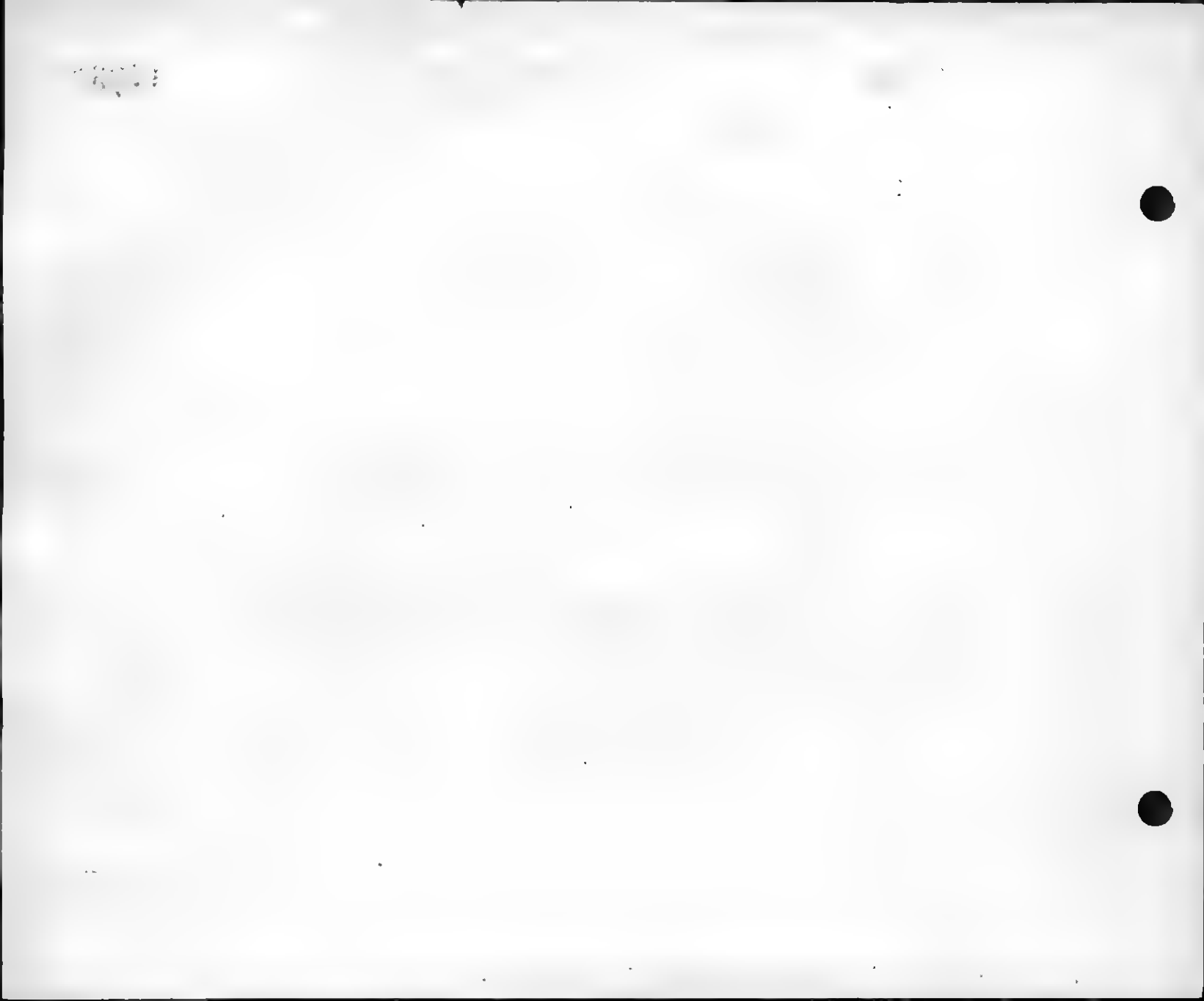
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14337

CERTIFICATE OF DEATH

14337

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>--</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. LENGTH OF STAY IN 1b <b>Washington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Hall Sanitarium</b>				d. STREET ADDRESS <b>3723 Jenifer St., N. W.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Proctor L. Dougherty</b>				4. DATE OF DEATH Month Day Year <b>Oct. 15 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9. 1873</b>	9. AGE (In years last birthday) <b>93</b> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Michael A. Daugherty</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Proctor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>579-44-1927</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, terminal</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Leukemia, lymphatic, chronic</b> DUE TO (c) <b>Arteriosclerosis, generalised</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS</b> <b>7 YRS</b> <b>10 YRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , to <b>OCT 15, 1966</b> , that (I) (we) last saw the deceased alive on <b>OCT 14, 1966</b> , and that death occurred at <b>5:40 P.M.</b> from causes and on the date stated above							
22a. SIGNATURE <b>Stewart Clapp M.D.</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-15-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Stewart Clapp M.D.</b>			22d. ADDRESS <b>4740 Chevy Chase Dr. Chevy Chase Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>10/16/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lees Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>			
24. FUNERAL DIRECTOR <b>J. Wm. Lees Sons</b>			ADDRESS <b>Washington, D. C.</b>		25a. REC'D BY REGISTRAR <b>OCT 18 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23c 11/1/66 5 pc

14338

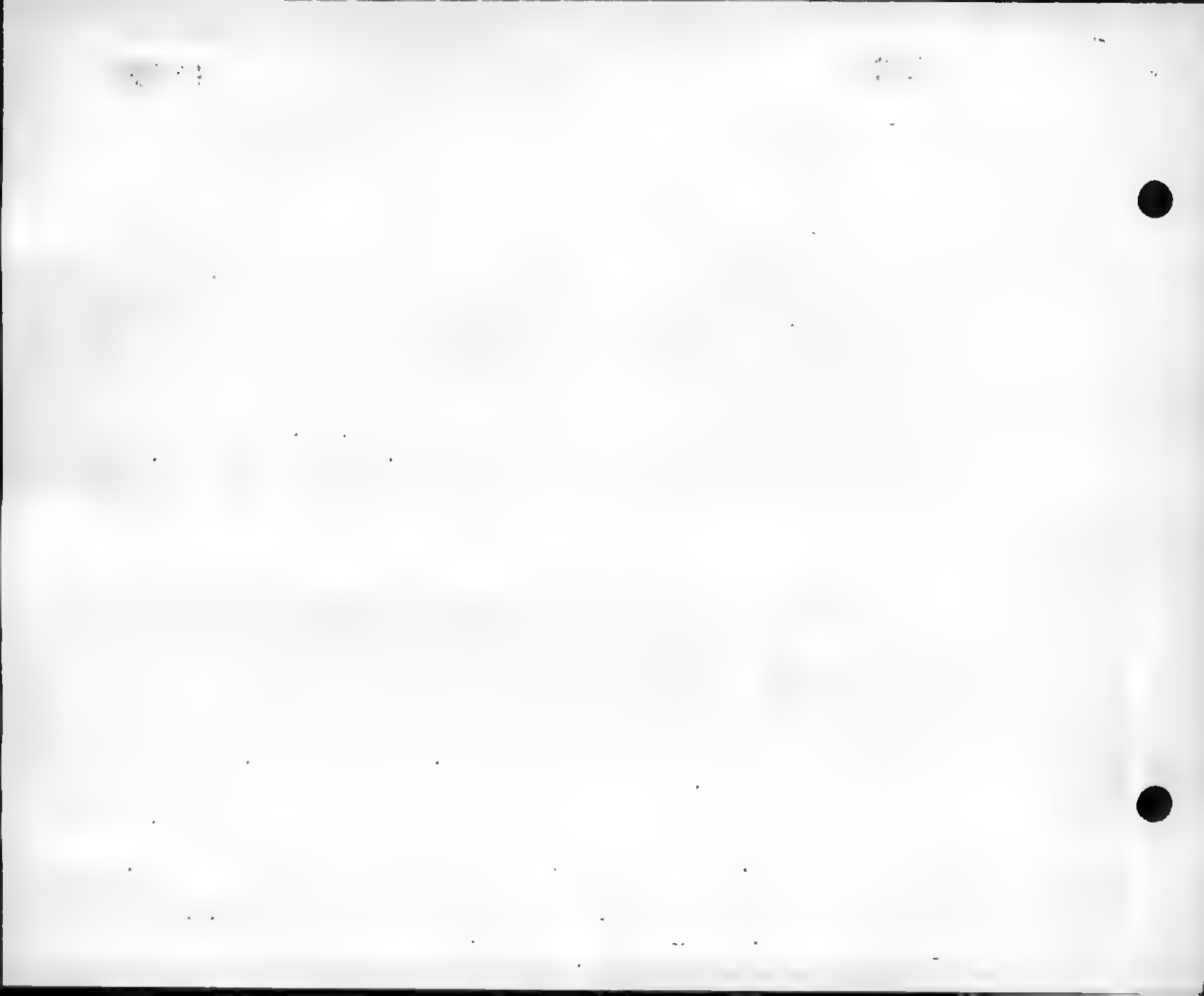
## CERTIFICATE OF DEATH

14338

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>9 Coral Place</b>	
3. NAME OF DECEASED (Type or print) First <b>Jay</b> Middle <b>Aloy</b> Last <b>Dubert</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>16</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1966</b>
9. AGE (In years last birthday) yrs <b>3</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b>	11. IF UNDER 24 HRS Hours <b>11</b> Min. <b>11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Patuxent River, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard C DUBERT</b>		14. MOTHER'S MAIDEN NAME <b>Bonnie Lee MEKUS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Park, Md.</b>		Address <b>Richard C. Dubert, 9 Coral Pl. Lexington</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomembranous enterocolitis with fibro purulent peritonitis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>Oct. 16, 1966</b> , to <b>Oct. 16, 1966</b> that (1) (we) last saw the deceased alive on <b>Oct. 16, 1966</b> , and that death occurred at <b>8:10 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE  M.D.		22b. DATE SIGNED <b>Oct. 17, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jerry J. Tomasovic, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>10-18-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Dunkirk, N.Y.</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> ADDRESS <b>Md.</b> <b>Funeral Home, 7557 Wisconsin Ave. Bethesda/</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 20 1966</b>	
25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14339

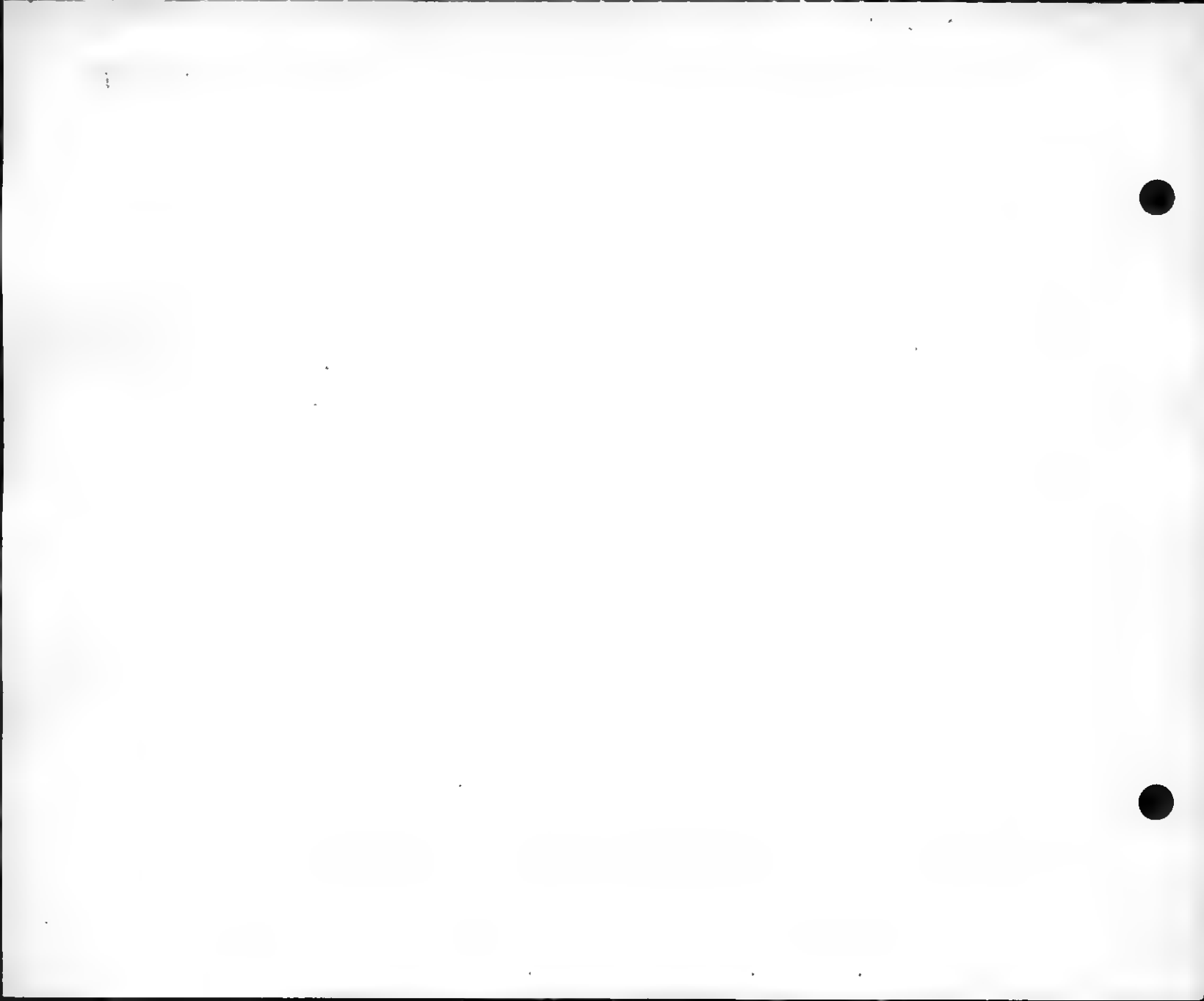
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14339

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural German town.</u>		c LENGTH OF STAY IN 1b <u>1 yr.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Snyders Trailer Haven.</u>		d STREET ADDRESS <u>Snyders Trailer Haven.</u>	
3. NAME OF DECEASED (Type or print) <u>Lawrence Ege.</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1916</u>
9. AGE (In years last birthday) <u>50 yrs</u>		10. IF UNDER 1 YEAR Months <u>50</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, Dc.</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Lewis Ege</u>		14. MOTHER'S MAIDEN NAME <u>Helen Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>23-18-9602</u>	
17. INFORMANT <u>Mary Loy Ege. As #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency, acute.</u> DUE TO (b) <u>201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>201</u> DUE TO (c) <u>201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>10/21/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-25-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Massachusetts</u>	23d. LOCATION (City or Town) (County) (State) <u>Woodstock Va.</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner. Gaithersburg, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 25 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

14341

**CERTIFICATE OF DEATH**

14342

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

<b>PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>20 days</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md. Silver Spring 151</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>		d. STREET ADDRESS <u>2308 Colston Drive</u> <u>5505 Queens Chapel Rd.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Minnie Barton Elder</u>		<b>4. DATE OF DEATH</b> Month <u>Oct</u> Day <u>3</u> Year <u>1966</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4-3-91</u>
<b>9. AGE</b> (n years last birthday) <u>75</u> yrs		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NONE</u>
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>America</u>	
<b>13. FATHER'S NAME</b> <u>Harry Mankin</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Katherine Dent</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO</b> <u>213 5-9311</u>	<b>17. INFORMANT</b> <u>med records</u>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute coronary artery thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery atherosclerosis</u> DUE TO (c) _____		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>12 hr</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____ 19____	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from _____, 1964, to 3 Oct., 1966, that (I) (we) last saw the deceased alive on 3 October 1966 and that death occurred on 3 Oct. P.M., from causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Morrill C. Quinnam Jr.</u> M.D.		<b>ATTENDING PHYS</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS</b> <input type="checkbox"/>	<b>22b. DATE SIGNED</b> <u>10-5-66</u>
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>MORRILL QUINNAM</u>		<b>22d. ADDRESS</b> <u>831 Univ. Blvd. Silver Spring, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE THEREOF</b> <u>6 Oct 1966</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Congressional Cem.</u>	<b>23d. LOCATION (City or Town) (County) (State)</b> <u>Washington D.C.</u>
<b>24. FUNERAL DIRECTOR</b> <u>JOSEPH CRAWLERS SONS</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE OCT 7 1966</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

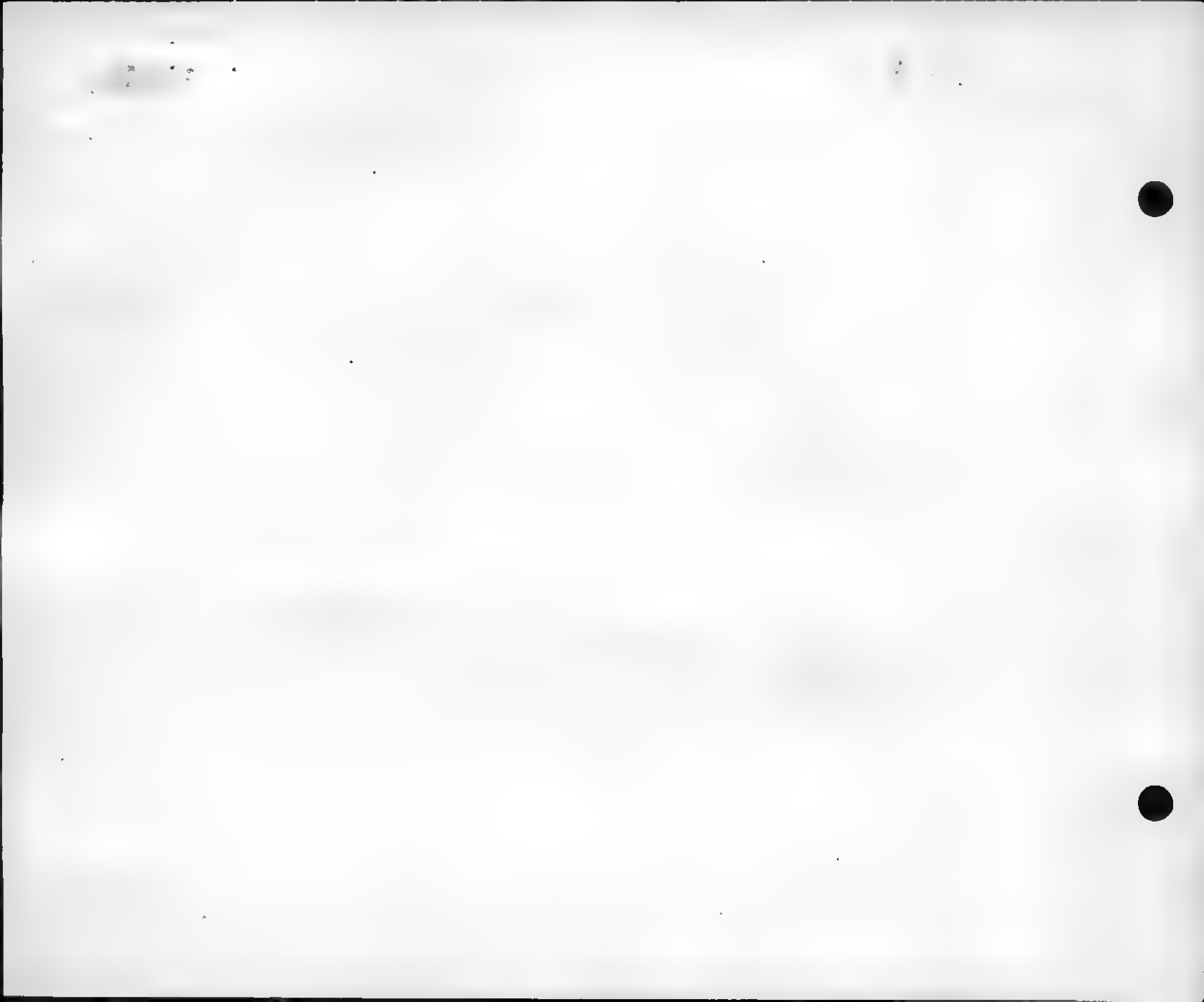
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14340

CERTIFICATE OF DEATH

14340

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>		c. LENGTH OF STAY IN TB <u>20 YRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7731 ROXTON COURT</u>		d. STREET ADDRESS <u>7731 ROXTON COURT</u>	
3. NAME OF DECEASED (Type or print) <u>ESTHER</u> First Middle Last		4. DATE OF DEATH <u>OCT.</u> Month Day Year <u>4</u> 19 <u>66</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 3, 1896</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS KOENICK</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>DR. BLAINE FIG (SON)</u> Address <u>7731 ROXTON COURT</u>			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIO-SCLEROSIS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>2 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19 <u>to OCT. 4</u> , 1966 that (I) (we) last saw the deceased alive on <u>OCT. 3</u> 1966, and that death occurred at <u>1 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Saul Zuckerman</u> M.D.		22b. DATE SIGNED <u>10-4-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAUL ZUCKERMAN</u>		22d. ADDRESS <u>5410 CONNECTICUT AVE N.W.</u>	
23a. BURIAL, CREMATION, or other disposition <u>BURIAL</u>		23b. DATE THEREOF <u>10-5-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>OXON HILL, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY &amp; SONS WASHINGTON DC</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 7</u> 1966	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



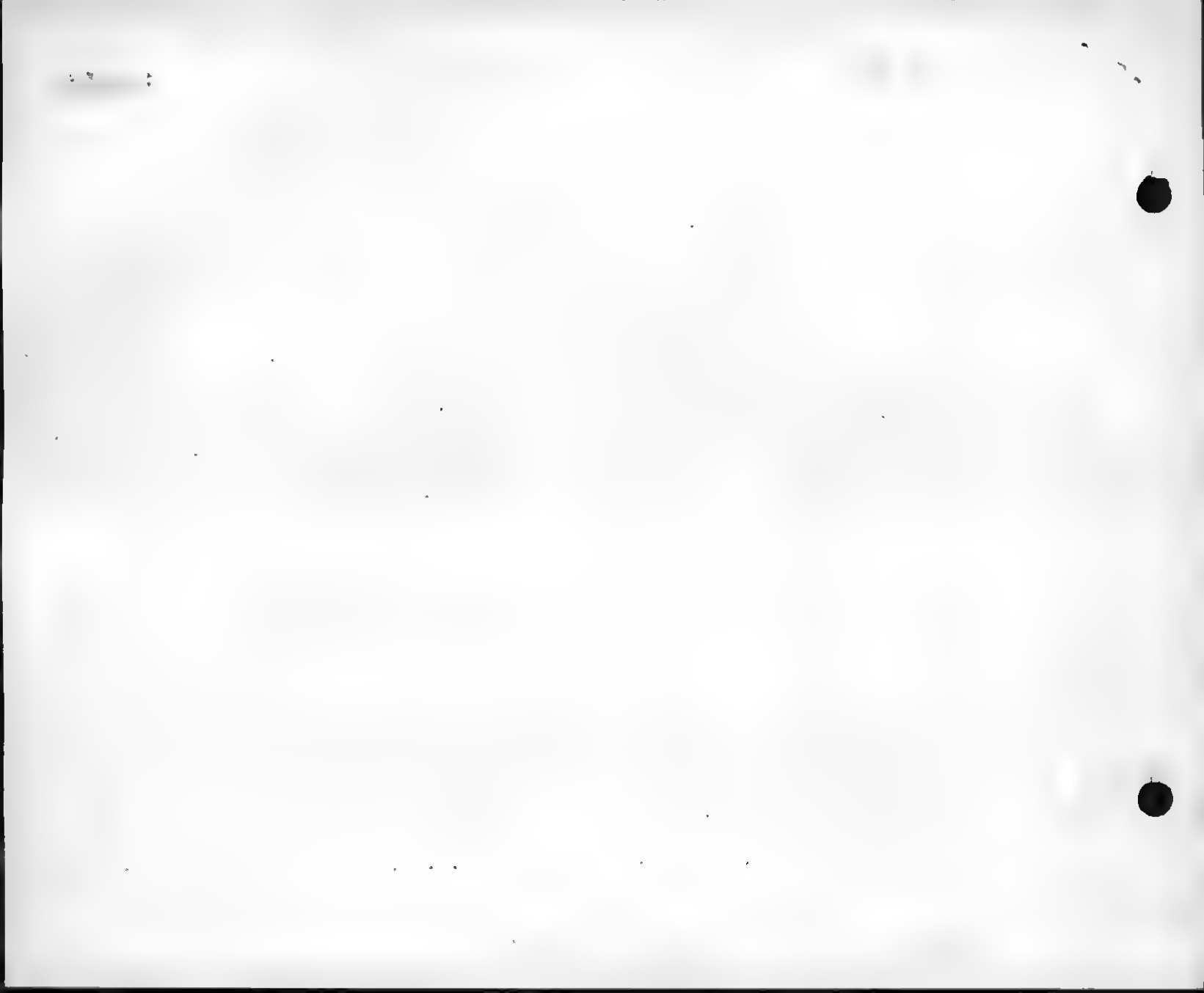
**14342**

**CERTIFICATE OF DEATH**

**14341**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Resident before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>10 Days</b>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Arlington</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>				d. STREET ADDRESS <b>421 North Monroe Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sandra Louise ELIOT</b>				4. DATE OF DEATH Month Day Year <b>October 15 19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 May 1952</b>	
9. AGE (In years last birthday) <b>14</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (County & State, or foreign country) <b>Monterey, California</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		13. FATHER'S NAME <b>Joe ELIOT</b>	
14. MOTHER'S MAIDEN NAME <b>Luz Goenaga</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>N/A</b>			
16. SOCIAL SECURITY NO. <b>N/A</b>				17. INFORMANT <b>Joe ELIOT, CAPT/USN</b>			
18. ADDRESS <b>421 North Monroe St. Arlington, Virginia</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia Gram Negative Aplastic Anemia</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>5 October 19 66</u> to <u>15 October 19 66</u> , that (X) (we) last saw the deceased alive on <u>15 October 19 66</u> , and that death occurred at <u>541P</u> M, from causes and on the date stated above							
22a. SIGNATURE <i>Merlin G. Otteman</i>				22b. DATE SIGNED <b>16 October 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Merlin G. OTTEMAN, LCDR MC USNR</b>	
22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-18-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home</b>				25a. REC'D BY REGISTRAR <b>CT 20 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

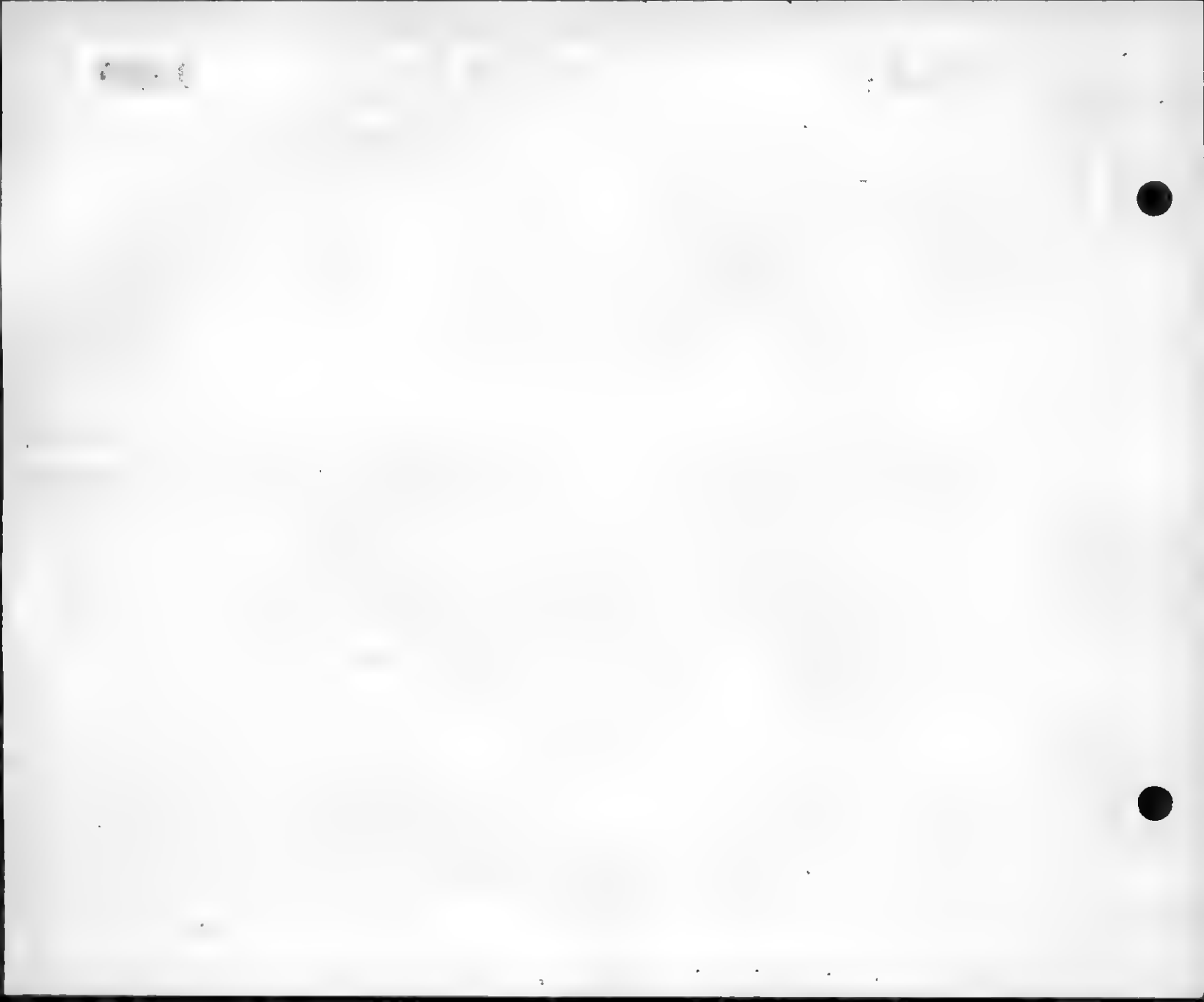
14343

CERTIFICATE OF DEATH

14343

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA-SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BETHESDA-SILVER SPRING NURSING HOME</b>		d. STREET ADDRESS <b>8207 GRUBB ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>EVA ETELSON</b>		4 DATE OF DEATH Month <b>OCTOBER</b> Day <b>3</b> Year <b>1966</b>	
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9 AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>LITHUANIA</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ABBA POSNER</b>		14. MOTHER'S MAIDEN NAME <b>SHANA RIVA</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>NO</b>	
17. INFORMANT <b>MRS. RENA BECKER</b>		Address <b>TAKOMA PARK, MD.</b> <b>7520 MAPLE AVENUE</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CEREBRAL THROMBOSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 WK</b> <b>6 MOS.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL</b> , 19 <b>66</b> to <b>3 OCT</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3 OCT</b> 19 <b>66</b> , and that death occurred at <b>4:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>WALTER E. GOOZH MD</b>		22b. DATE SIGNED <b>3 OCT 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER E. GOOZH MD</b>		22d. ADDRESS <b>2390 GLENMONT CIR WHEATON MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/5/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BNAI ISRAEL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24 FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 5 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

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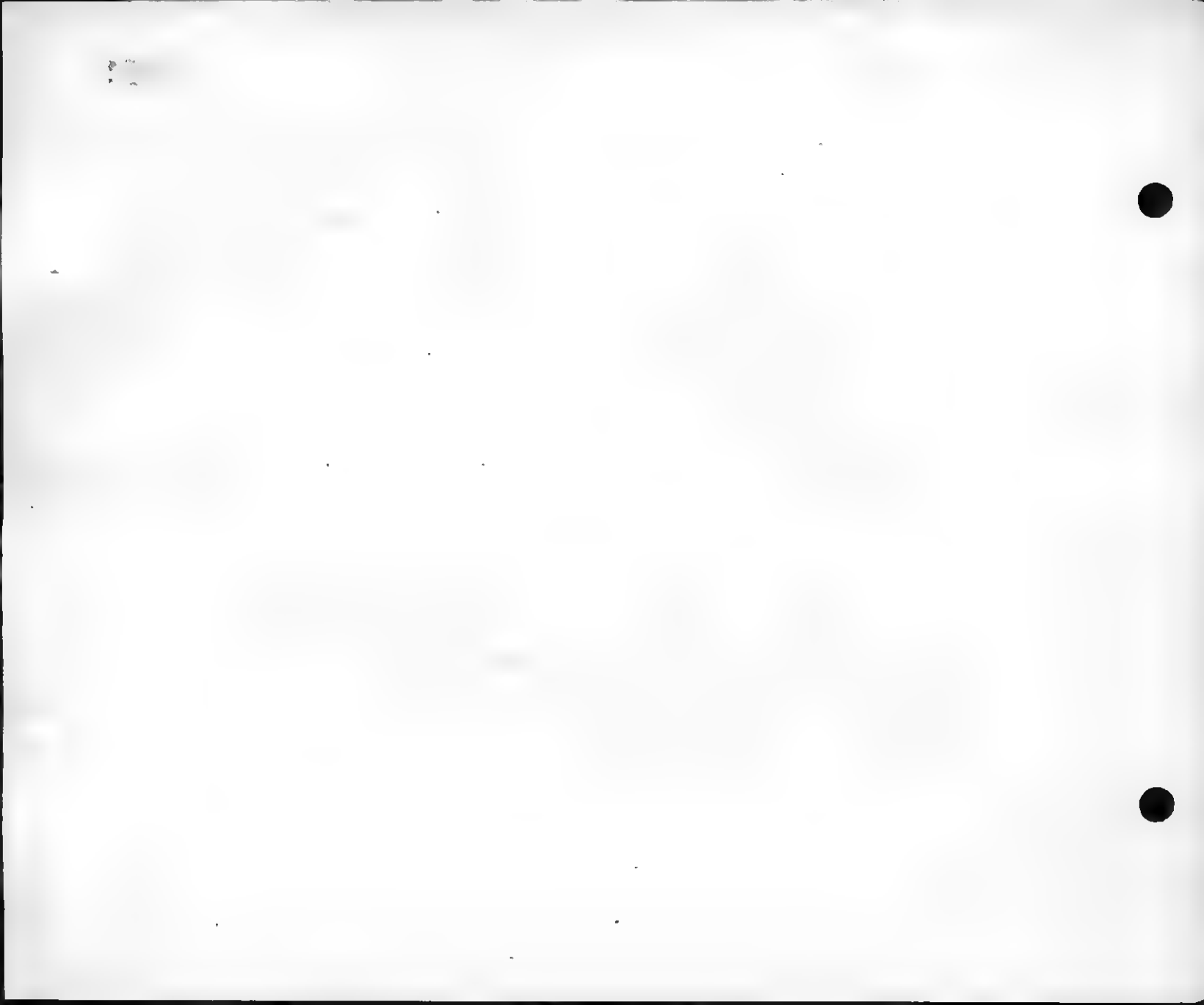
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14344

CERTIFICATE OF DEATH

14344

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6307-Wynkoop Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Joan</u> Middle <u>R.</u> Last <u>Farrar</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/23/25</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		9b. AGE (In years last birthday) <u>41</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John R. Farrar</u>		14. MOTHER'S MAIDEN NAME <u>Robertta Becker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mrs. Roberta B. Farrar, Mother</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Hyperparathyroidism</u> DUE TO (c) <u>Parathyroid Adenoma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/6</u> , 19 <u>66</u> to <u>10/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> , 19 <u>66</u> , and that death occurred at <u>2:45 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edgar H. Levitt</u> M.D.		22b. DATE SIGNED <u>10/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDGAR H. LEVITT</u>		22d. ADDRESS <u>8218 Wisconsin Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 18, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, New York</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Wash. DC</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 19 1966</u>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in only one case within 72 hours after death.

VR A15ME (5)  
6M 1/66

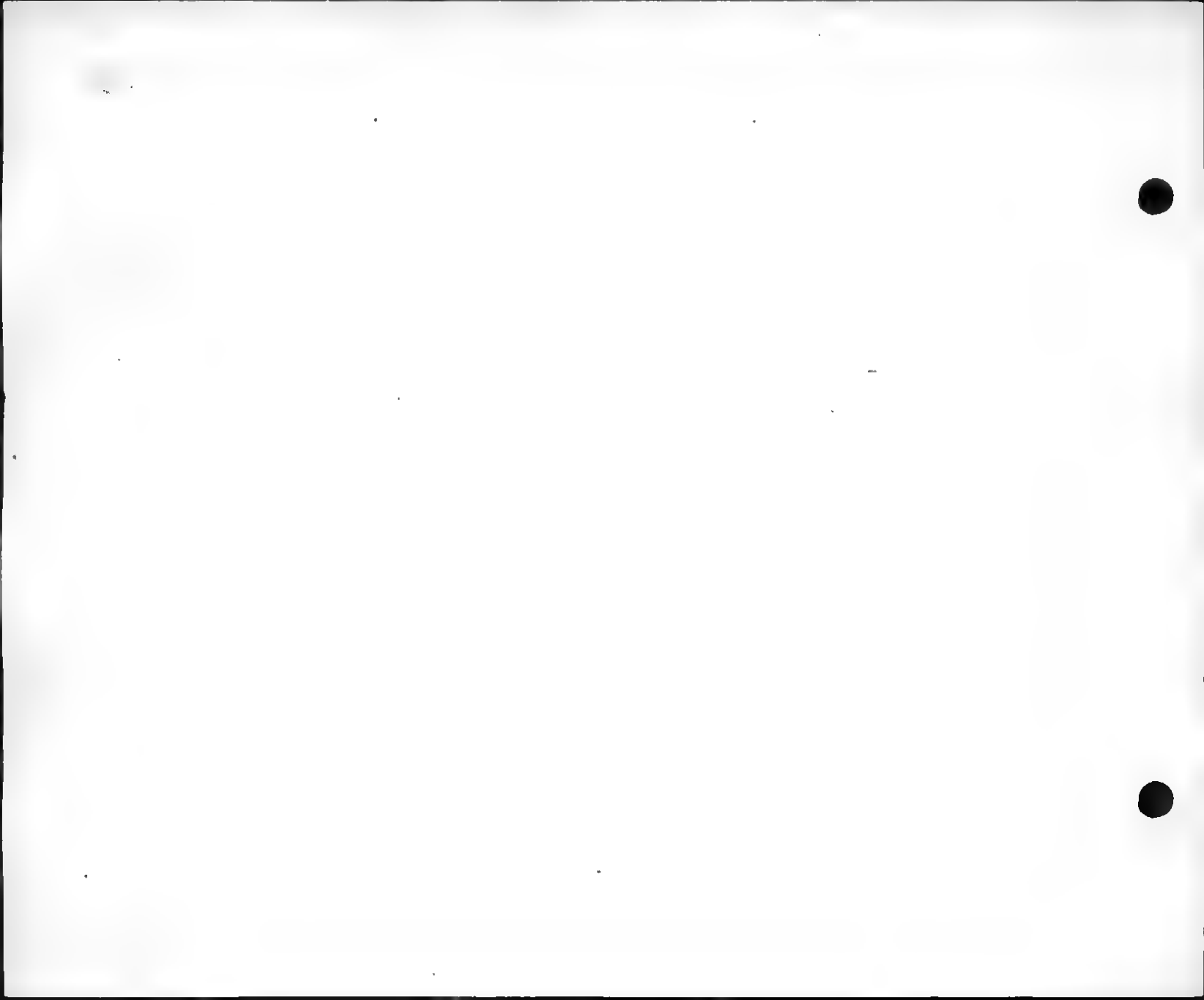
## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14345

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14345

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rural Damascus</u>		c LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Route B - Mt Airy Dewey Brook Farm</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Custer</u> Last <u>Fawsett</u>		4 DATE OF DEATH Month <u>Oct</u> Day <u>19</u> Year <u>1966</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept 26 1908</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Cattle Dealer</u>		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (in years last birthday) <u>58</u> YRS
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Howard C. Fawsett</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth Williams</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Miss Elizabeth Fawsett, Silver Spring, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> (c) <u>Sudden</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. — p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>10/19/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Oct. 22, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rockville</u>	23d LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>		25a REC'D BY REGISTRAR DATE <u>OCT 24 1966</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14346

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14346

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b COUNTY <u>Mont. Co.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY N 1b <u>3 hrs.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>10201 Grosvenor Pl.</u>	
3 NAME OF DECEASED (Type or print) <u>Ethel Wagner Feldherr</u>		4 DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 30, 1901</u>
9 AGE (In years last birthday) <u>65</u> yrs.		10 IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11 BIRTHPLACE (State or foreign country) <u>Roumania</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Abraham Schacker</u>		14 MOTHER'S MAIDEN NAME <u>Frema Wagner</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>  </u>		16 SOC. A. SECURITY NO. <u>230-48-9541</u>	
17 INFORMANT <u>Lew Feldherr</u>		Address <u>5402 Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - Acute</u> 4261 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/5/66</u>	
		Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>10-7-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>MT. HEBRON Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>FRUSHING, N.Y.</u>
24 FUNERAL DIRECTOR <u>CONDORGE FUNERAL HOME</u>		25a REC'D BY REGISTRAR DATE <u>OCT 7 1966</u>	
ADDRESS <u>4217 9th St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14347

## CERTIFICATE OF DEATH

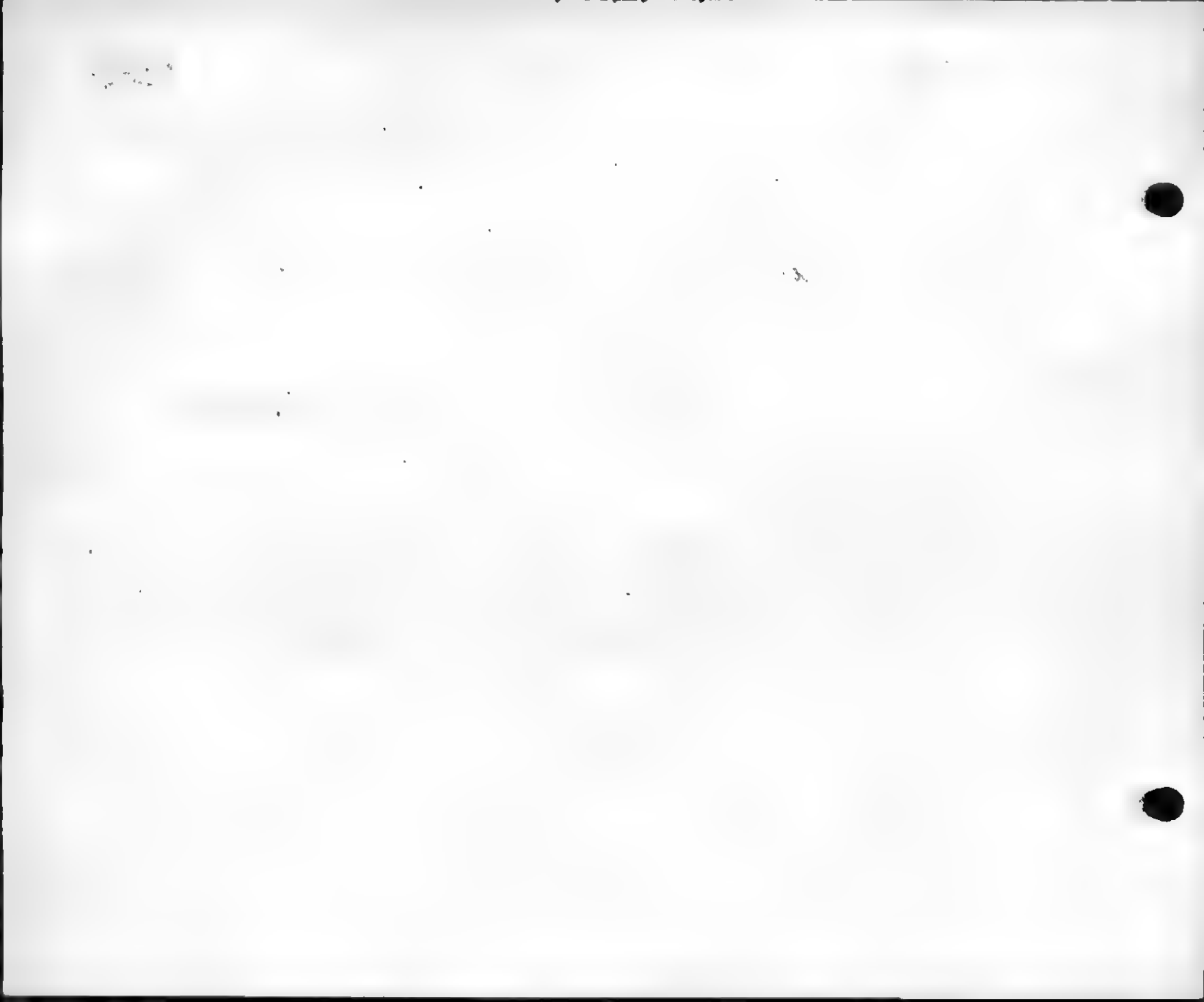
14347

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>1123 Quebec St</u>	
3. NAME OF DECEASED (Type or print) <u>Celia</u> First <u>Farber</u> Middle <u>Farber</u> Last		4. DATE OF DEATH <u>Oct. 31</u> 19 <u>66</u> Month <u>Oct.</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/26/84</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown - Goldman</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>Hosp Records</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Coronary failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>AS HD</u> (b) <u>AS HD</u> (c) <u>AS HD</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>bronchopneumonia, diabetes</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> , 19 <u>66</u> , to <u>10/31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/31</u> 19 <u>66</u> and that death occurred at <u>9:19</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Jay R. Shapiro</u> M.D.		22b. DATE SIGNED <u>10/31/66</u>	
22c. PHYSICIAN NAME (Type) <u>JAY R. SHAPIRO</u>		22d. ADDRESS <u>8218 Wisconsin Ave - Beth, Md</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-2-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>ROCHELLE PARK - N. J.</u>
24. FUNERAL DIRECTOR <u>B. Ganzansky &amp; Son</u> ADDRESS <u>3501 - 4th St</u>		25a. REC'D BY REGISTRAR <u>Nov 3 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be removed from the certificate and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

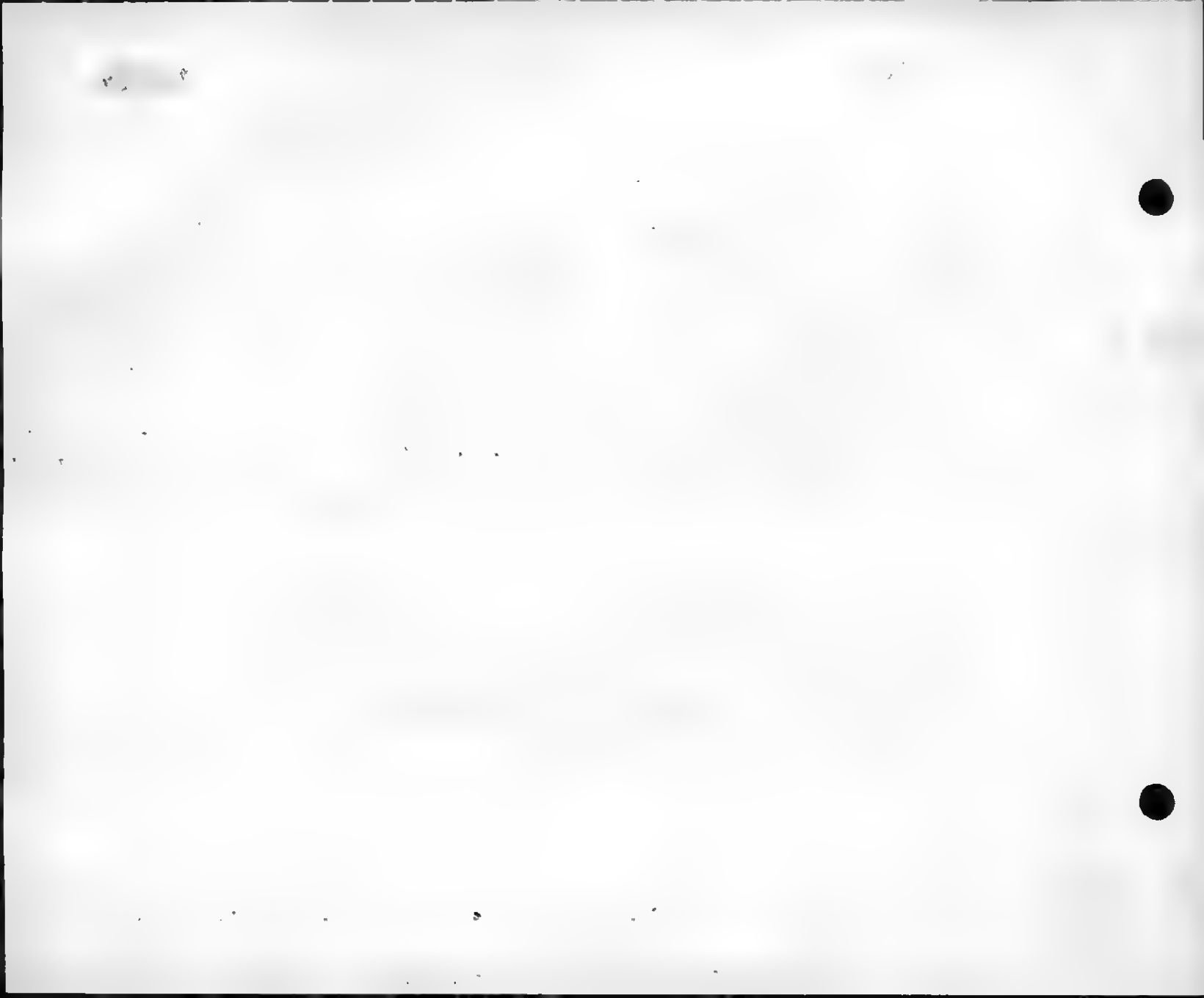
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14348

14348

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 Wks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>9037 Manchester Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Amelia Fischer</u>		4 DATE OF DEATH <u>October 6</u> 19 <u>66</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Sept. 22, 1885</u> 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME (Unknown) <u>O'Halloran</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO <u>220-48-7568</u>	
17 INFORMANT <u>Mr. G. Frederick Speckel</u>		Address <u>9037 Manchester Rd. Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral arterial thrombosis</u> DUE TO <u>1221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized arteriosclerotic cardiovascular disease</u> DUE TO <u>1-2 yrs</u> (c) <u>Exaggerated heart failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>66</u> , to <u>6 Oct</u> , 1966, that (II) (we) last saw the deceased alive on <u>6 Oct</u> , 19 <u>66</u> , and that death occurred at <u>11:55</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Ernest E. Harmon M.D.</u>		22b. DATE SIGNED <u>6 Oct 66</u>	
22c PHYSICIAN'S NAME (Type) <u>Ernest E. Harmon MD</u>		22d ADDRESS <u>9301 Cokesville Rd Silver Spring, Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Oct 10, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Kensico Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Mt. Airy, New York</u>
24 FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 10 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

14349

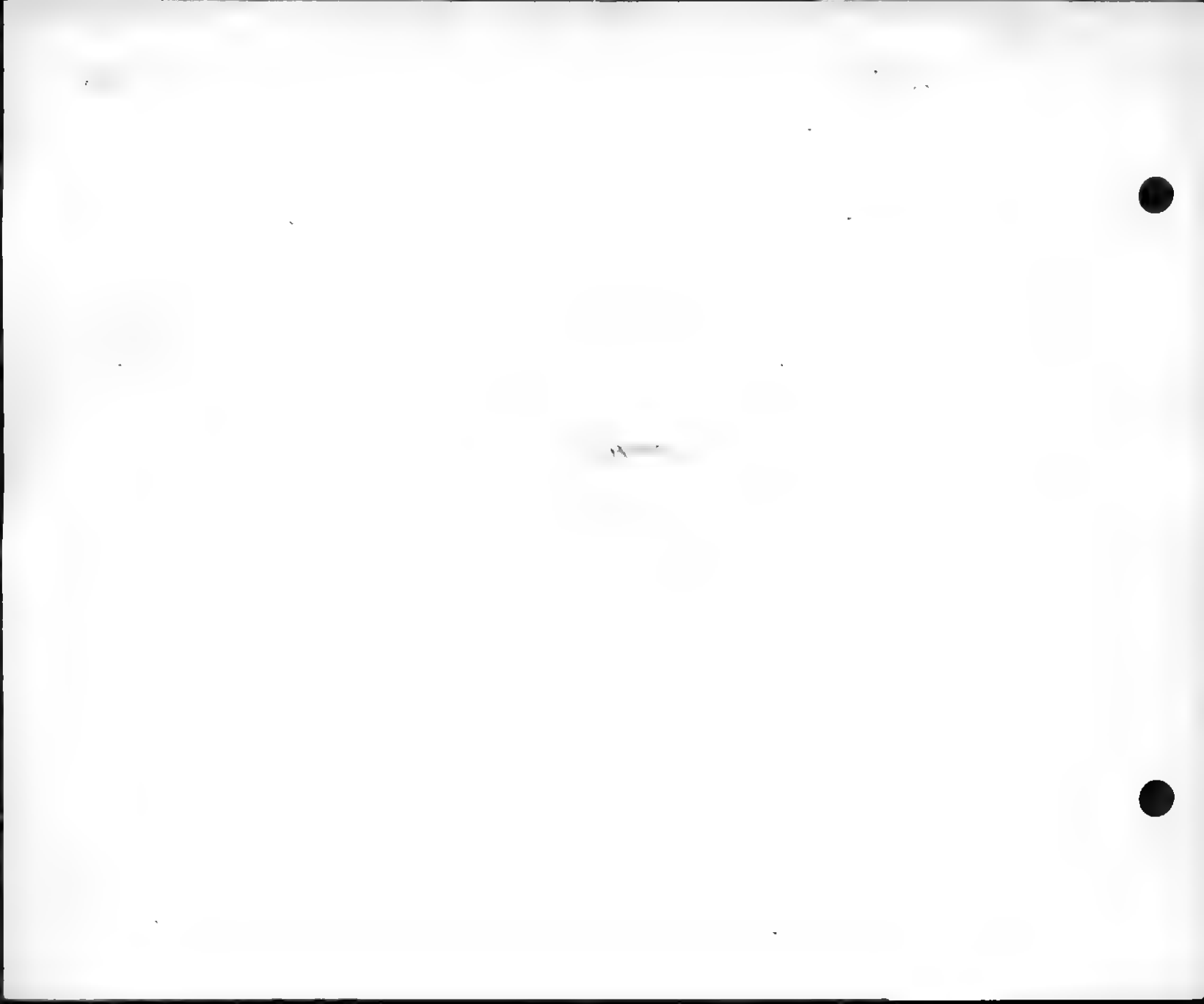
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14349

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		d. STREET ADDRESS <u>404 Greenlawn Dr</u>	
3 NAME OF DECEASED (Type or print) <u>HAZEN WILLIAM FLEET</u>		4 DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-30-01</u>
9 AGE (in years lost birthday) <u>64</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>	
11 BIRTHPLACE (State or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Frederick Fleet</u>		14. MOTHER'S MAIDEN NAME <u>Eva Bullis</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16 SOC. A. SECURITY NO. <u>108-100176</u>	
17 INFORMANT <u>Life - Mrs. Clara B. Fleet</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Acute bilateral bronchopneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <u>Pulmonary emphysema, marked</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MED. CAL. EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>	
		DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, City, town, or county)	
22. DATE SIGNED <u>Oct. 7, 1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10 Oct 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24 FUNERAL DIRECTOR <u>Green Carter</u> <u>48434 Georgia Avenue</u> <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 13 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

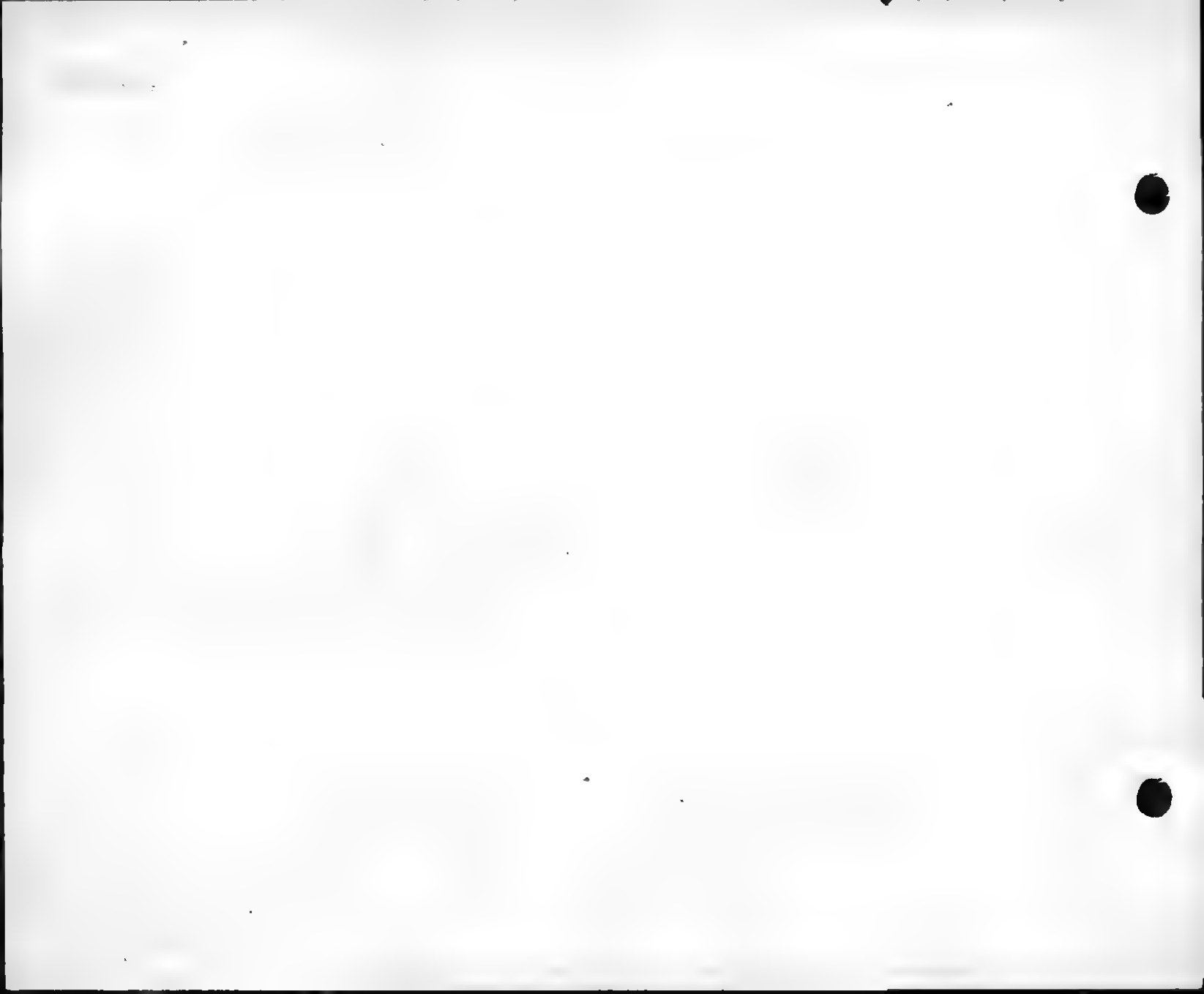
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14350

14350

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c LENGTH OF STAY in 1b <u>35 days.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>Rt # 1</u>	
3 NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>R</u> Last <u>Flood</u>		4 DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>M</u>	6 COLOR OR RACE <u>C</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-1-01</u>
9 AGE (In years last birthday) <u>65</u> yrs		10 IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALBY'S DELICATESSEN</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>PHIL., PA.</u>		12. CIT ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Flood</u>		14. MOTHER'S MAIDEN NAME <u>ANNA V. Flood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Army</u>		16. SOCIAL SECURITY NO <u>197-09-70039</u>	
17. INFORMANT <u>MARY Louise Kelly Flood</u>		Address <u>1614 Edgeton, St</u> <u>PHIL., PA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic Renal Failure</u> DUE TO (c) <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 years</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Hypertensive Cardiovascular Disease; Pyelonephritis</u>			
20a. DECEASED WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/1</u> , 19 <u>66</u> , to <u>10/25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/24</u> , 19 <u>66</u> , and that death occurred at <u>3:4</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Robert C. Macon</u>		22b. DATE SIGNED <u>10/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Macon</u>		22d. ADDRESS <u>809 Viers Mill Rd. Rockville</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10/29/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Vernon</u>	23d. LOCATION (City or Town) (County) (State) <u>Philadelphia, Pa.</u>
24. FUNERAL DIRECTOR <u>Sam Butler Inc. Funeral Home</u> <u>3900 Georgia Ave. NW, Wash. DC.</u>		25a. REC'D BY REGISTRAR <u>Oct 26 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

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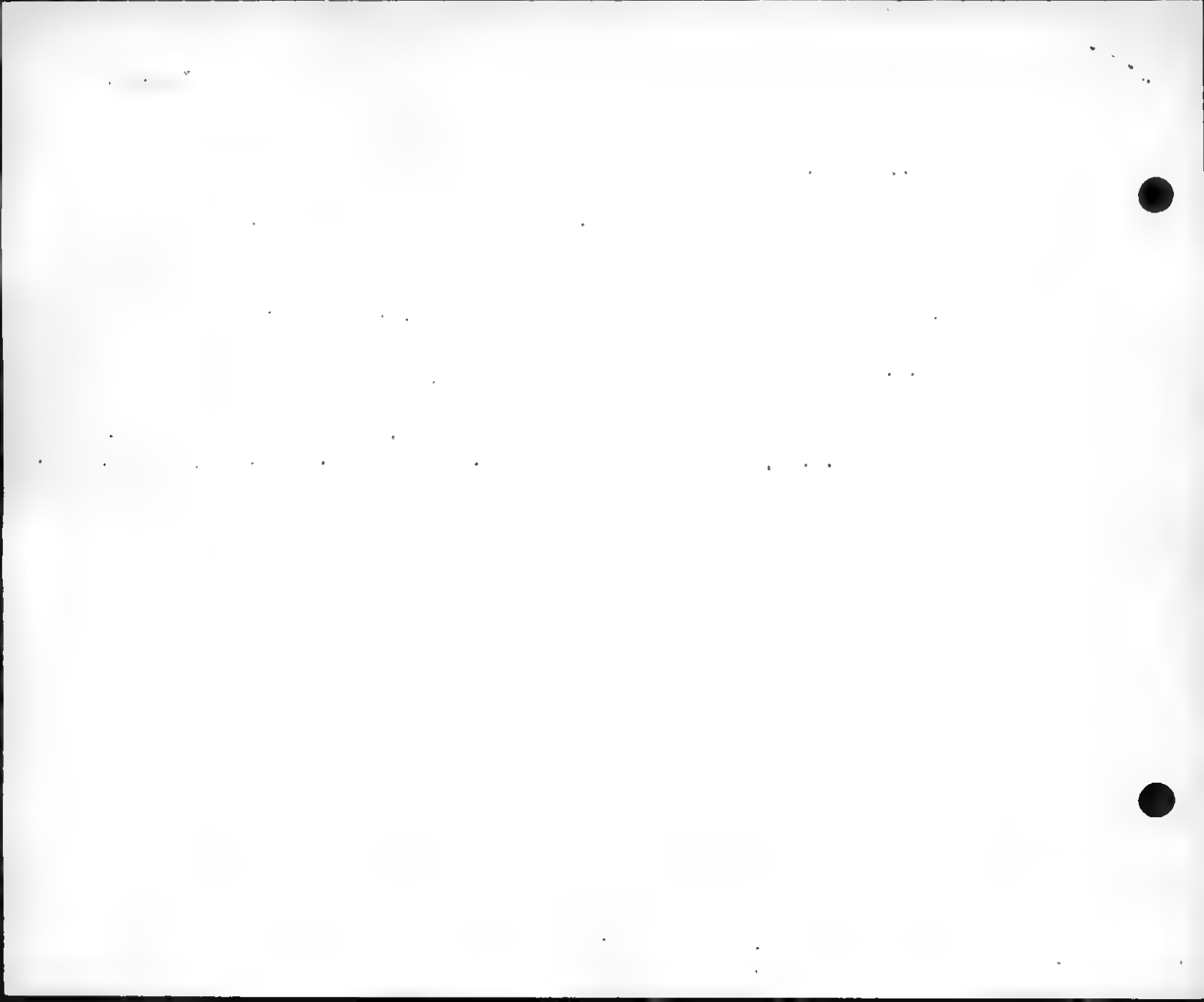
FOR STATE  
HEALTH DEPT.

14351

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14351

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>1615 Bradley Ave.</b>	
3 NAME OF DECEASED (Type or print) First <b>N</b> Middle <b>J</b> Last <b>FORD</b>		4 DATE OF DEATH Month <b>October</b> Day <b>9</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cauc</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 10, 1916</b>
9 AGE (In years last birthday) <b>50</b>		10 IF UNDER 1 YEAR Months Days Hours Min	
11 BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Unknown</b>		14 MOTHER'S MAIDEN NAME <b>Unknown</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W. #2</b>		16 SOCIAL SECURITY NO <b>426 01 7043</b>	
17 INFORMANT <b>P.O. Box 635, Rockville, Md.</b> <b>Mrs. Elizabeth S. Ford, 1615 Bradley Ave.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive myocardial infarction</b> 4-6 / DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b> EXAMINER'S NAME (Type) <b>BELOEN R. REAP, M.D.</b>		22. DATE SIGNED <b>OCT. 10, 1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-13-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> <b>7557 Wisconsin Ave., Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 13 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

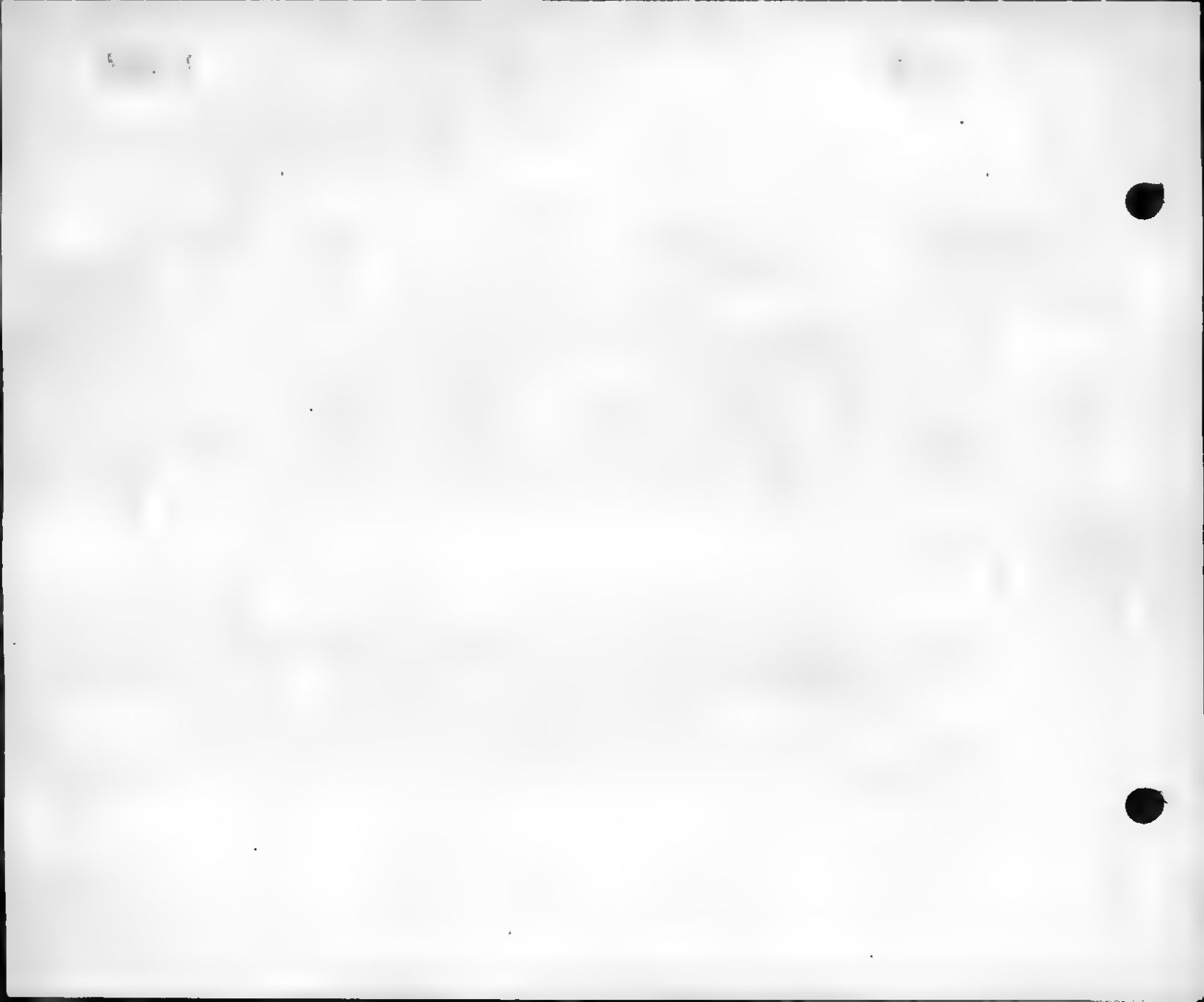
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14352

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14352

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>3 mos. 2 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nursing Home</u> <u>1000 Daleview Dr.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8505 Springvale Rd. Silver Spring</u> d. STREET ADDRESS <u>Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>McLissa</u> First <u>Francis</u> Middle <u>Francis</u> Last <u>Francis</u>		4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8, 1891</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER LAUNDRY</u> <u>St. Louis</u> <u>LAUNDRY</u> <u>Illinois</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>Illinois</u>	
13. FATHER'S NAME <u>William Davis</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>322-32-2310</u>	
17. INFORMANT <u>Mrs. Hazel F. Mibray</u> Address <u>Sil. Sp. Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>10/25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> , 19 <u>66</u> , and that death occurred at <u>7</u> P.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>A. F. Thibadeau</u>		22b. DATE SIGNED <u>10/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. F. THIBABEAU</u>		22d. ADDRESS <u>10111 COLESVILLE RD. SIL. SP. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-29-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn Memorial Park</u>		23d. LOCATION (City, town or county) <u>McLean County, Ill.</u> (State) _____	
24. FUNERAL DIRECTOR <u>Francis J. Collins</u> ADDRESS <u>3821-14th St. NW. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 28 1966</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

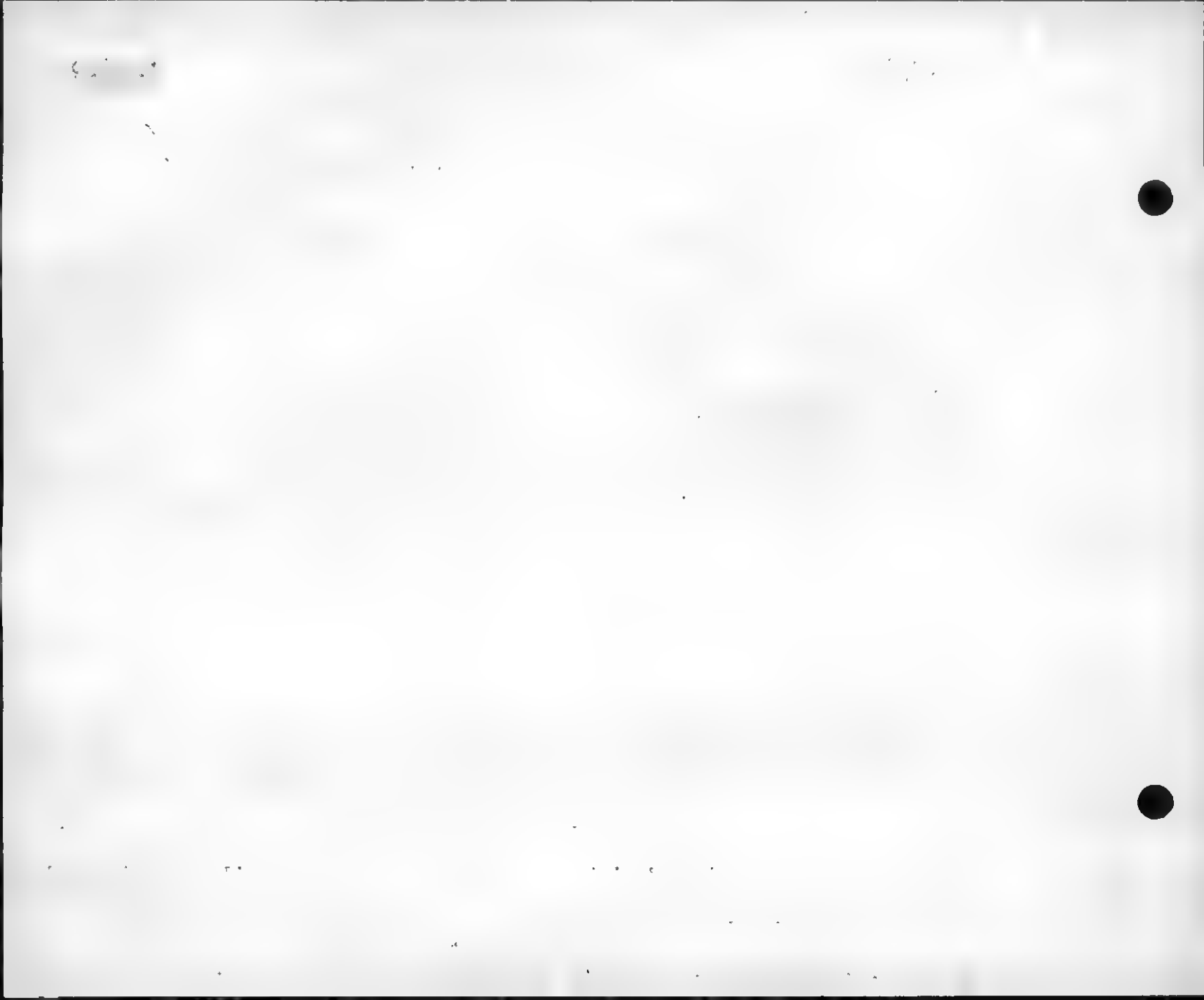
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14353

CERTIFICATE OF DEATH

14353

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY MD.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD.</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS Hospital</u>				d. STREET ADDRESS <u>8209 Schrider Street</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>SIGRID C FREY</u>				4. DATE OF DEATH Month Day Year <u>OCT 26 1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 25, 1902</u>	
9. AGE (In years last birthday) yrs <u>64</u>		10. IF UNDER 1 YEAR Months Days Hours Min <u>26 19 66</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ronneley, XX Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>Sweden</u>	
13. FATHER'S NAME <u>Johan Adolf Karlsson</u>				14. MOTHER'S MAIDEN NAME <u>Mathilda Johanna</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Karl Frey 8209 Schrider Street Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> DUE TO <u>Chronic Pyelonephritis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>Chronic Pyelonephritis</u> (c) <u>Chronic Pyelonephritis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> to <u>10/26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/26</u> , 19 <u>66</u> , and that death occurred at <u>12:45 AM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>William D. Aud</u>				22b. DATE SIGNED <u>10/26/66</u>		22c. PHYSICIAN'S NAME (Type) <u>William D. Aud, M.D.</u>	
22d. ADDRESS <u>9006 Colesville Rd., Silver Spring, Md.</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Wagner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or any other event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14354

CERTIFICATE OF DEATH

14354

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>			c. LENGTH OF STAY IN 1b <b>7/5/66</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington, Maryland</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>				d. STREET ADDRESS <b>3511 SANDY COURT</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>----</b> Last <b>Galler</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>1</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/15/81</b>	
9. AGE (In years last birthday) yrs <b>85</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Leon Worth</b>			
14. MOTHER'S MAIDEN NAME <b>Rachel Lutzsky</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>578-09-2425</b>				17. INFORMANT Address <b>Isadore Galler-3511 Sandy Ct. Kens. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Unknown</b>							INTERVAL BETWEEN ONSET AND DEATH <b>&lt; 1 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>66</b> , to present, 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>July 10</b> , 19 <b>66</b> , and that death occurred at <b>8:30 p.m.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>George Sharpe m.d.</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>George Sharpe</b>	
22d. ADDRESS <b>10400 Connecticut Ave Kensington Md</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/3/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>D.C. Lodge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>B. Banzansky Son</b>				25a. REC'D BY REGISTRAR <b>3501-14 St. N.W.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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10 10 3

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14355

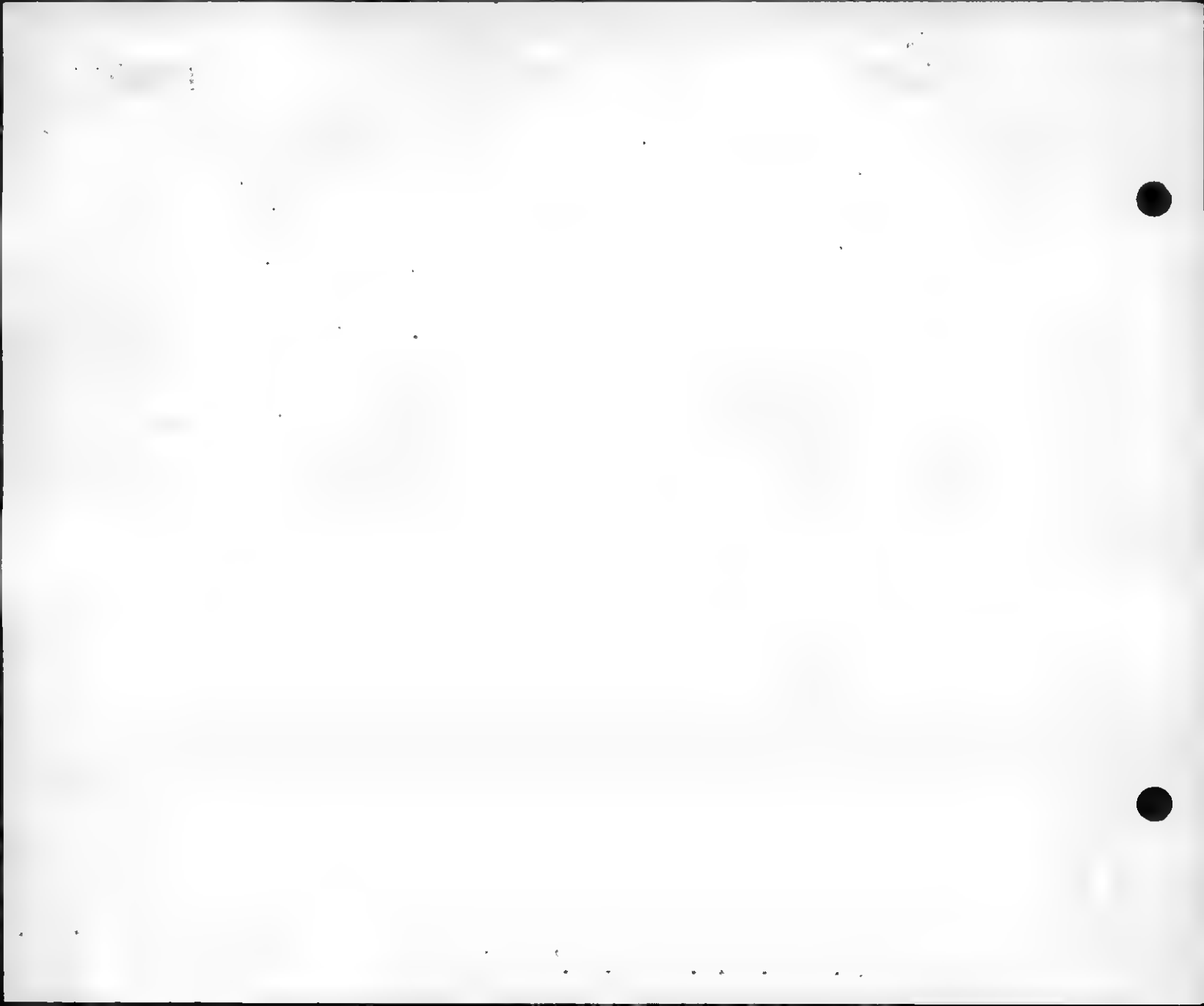
**CERTIFICATE OF DEATH**

14355

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>5420 Conn. Ave N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Rachel P. Leland</u> (First) Middle Last				4. DATE OF DEATH <u>10-14</u> 19 <u>66</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1897</u>	9. AGE (In years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. Emp.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James L. Leland</u>				14. MOTHER'S MAIDEN NAME <u>Anna Hood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service) <u>Yes W.W.I.</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs. Huggins</u> Address <u>10114 Ashmont Dr. Kensington, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular hemorrhage</u> Severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rupture of cerebral vessel</u> DUE TO (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>10-14</u> , 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>10-14</u> , 19 <u>66</u> , and that death occurred at <u>11:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Stewart Clapp M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>10-14-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>				22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-17-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>Oct 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
5130 Wisc. Ave. N.W. Wash. D.C.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

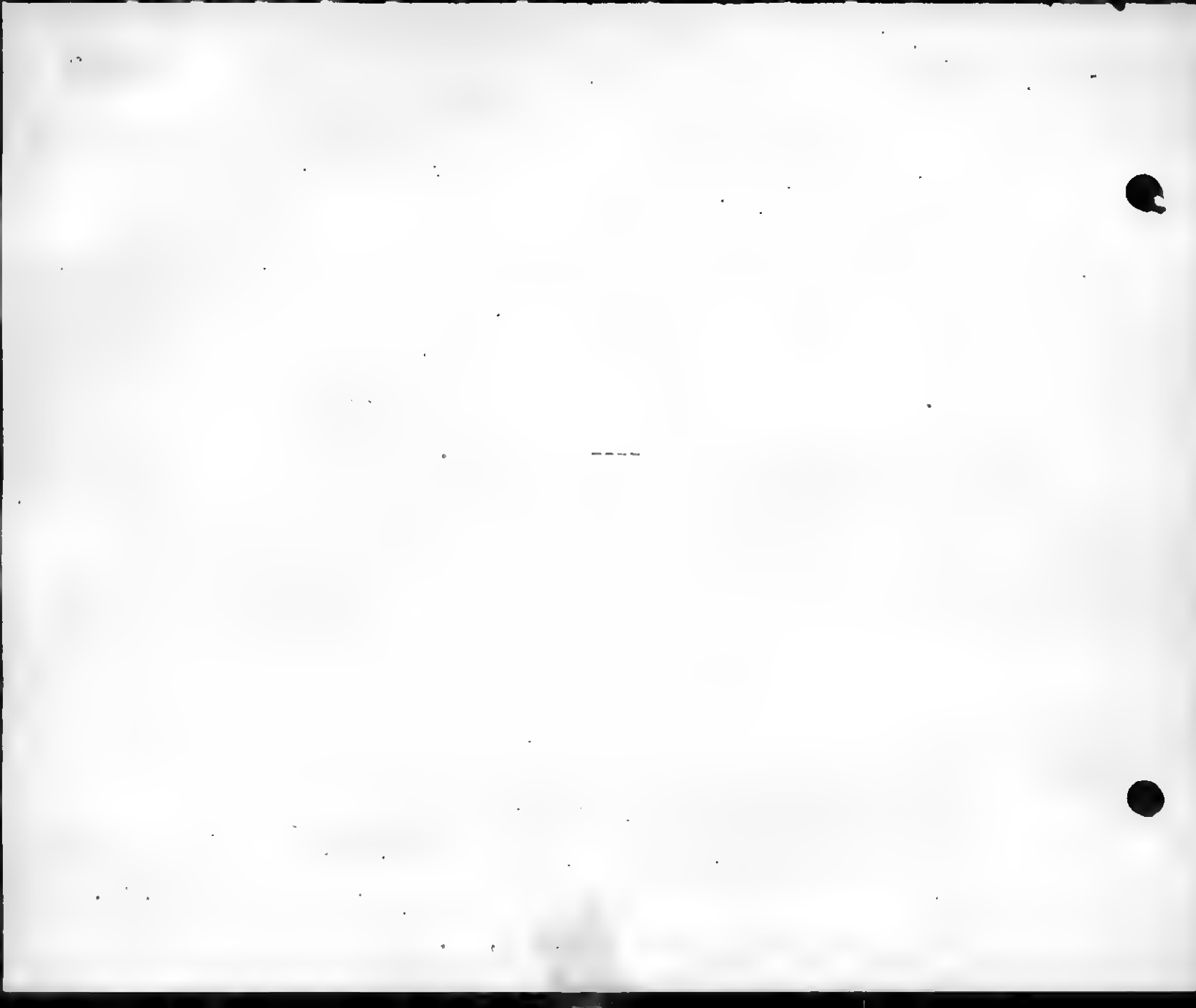
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MED. EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>14356</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>14356</div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>10 hours</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				e. STREET ADDRESS <u>408 Calvin Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gennifer Lynn Geyer</u>				4. DATE OF DEATH <u>October 19 1966</u>				5. AGE (In years last birthday) <u>19</u> Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 16, 1966</u>		9. AGE (In years last birthday) <u>19</u> Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Max A. Geyer</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Robinson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>----</u>				17. INFORMANT <u>Max A. Geyer (Father) same item #2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital heart disease with complete</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>interruption of Aortic arch, and descending</u> (c) <u>aorta arising from ductus arteriosus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>OCT. 19, 1966</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) <u>Silver Spring, Md.</u>		(State)	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>				ADDRESS <u>Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE	
				DATE <u>OCT 24 1966</u>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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14357

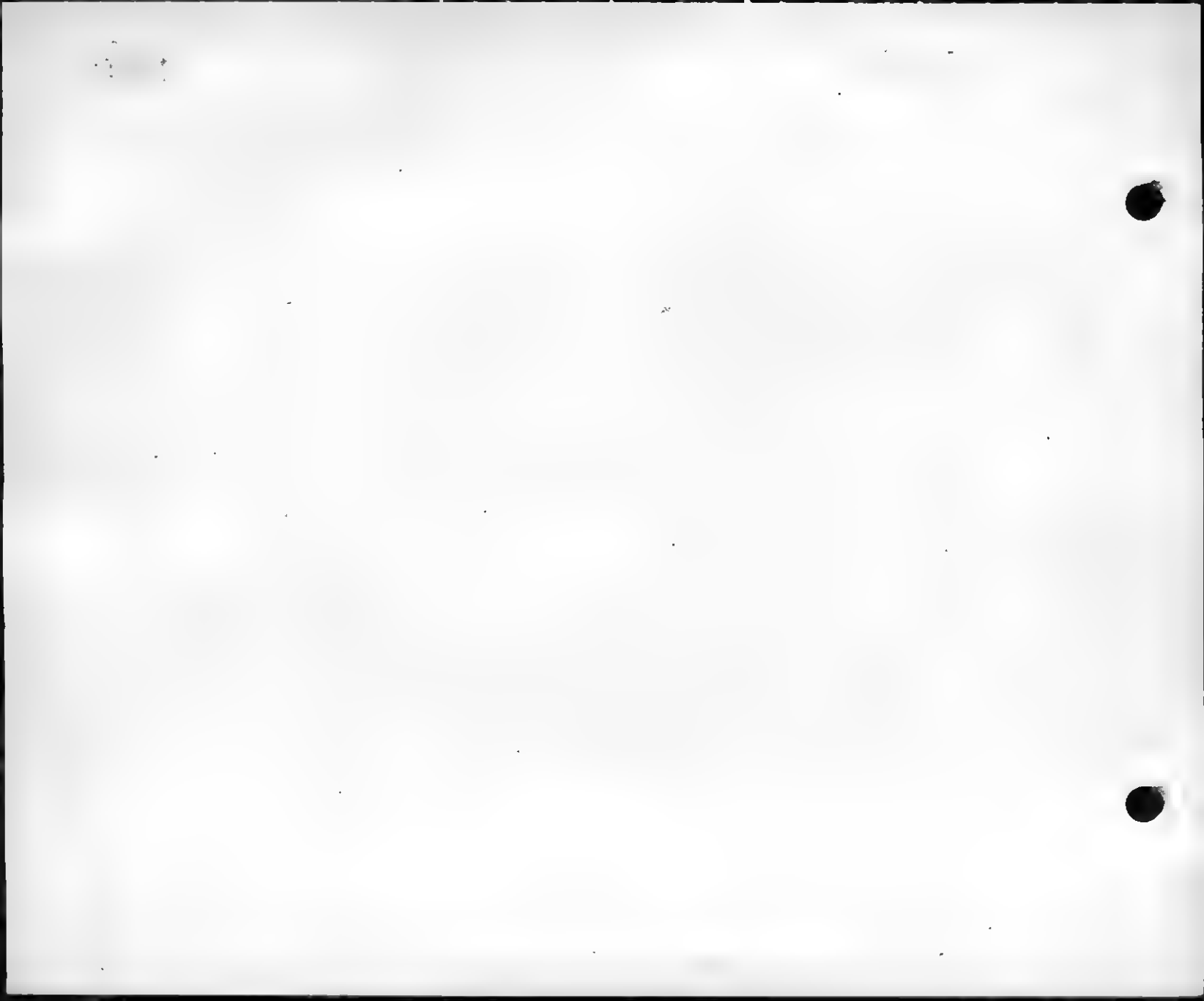
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14357

1. PLACE OF DEATH a. COUNTY <u>Mont.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15810 Bradford Rd. Silver Spring</u> c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bradford Rest Home, Silver Spring</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlottesville, Md.</u> d. STREET ADDRESS <u>1501</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ella May Gibson</u> First Middle Last		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-6-87</u> 9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hachett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bruce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-54-8695</u>	
17. INFORMANT <u>Record - Bradford Rest Home</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-20</u> , 19 <u>66</u> , to <u>10-30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-30</u> , 19 <u>66</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Clive E. Jackson</u>		22b. DATE SIGNED <u>10-30-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/3/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Cem.</u>	23d. LOCATION (City, town or county) (State) <u>CLARKSBURG, MD.</u>
24. FUNERAL DIRECTOR <u>George R. Snowden</u>		25a. REC'D BY REGISTRAR <u>Rockwell Co.</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>NOV 2 1966</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14358

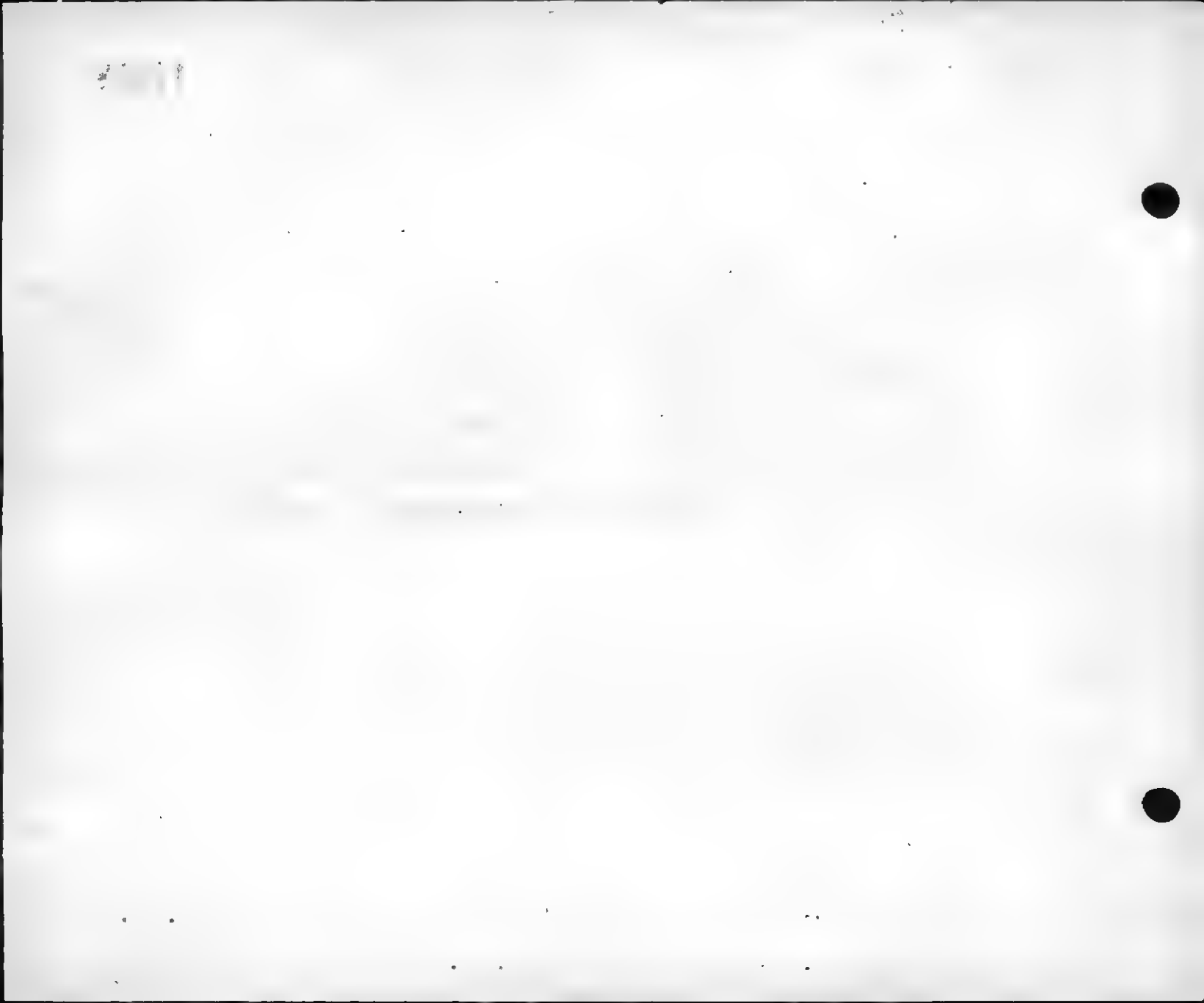
CERTIFICATE OF DEATH

14358

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) p. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>109 Beall Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Janet</u> Last <u>Goldstein</u>		4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/99</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>David Samet</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Bernice Grossman</u> Address <u>same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity, Fatty metaporphysis Liver,</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/2, 1964</u> to <u>10/31, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/31, 1966</u> and that death occurred at <u>4:40</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>10/31/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/2/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Agudas B'nai Jacob</u>	23d. LOCATION (City or Town) (County) (State) <u>Rosedale Balto. Md.</u>
24. FUNERAL DIRECTOR <u>JACK LEWIS, INC.</u> ADDRESS <u>2100 Eutaw Place Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 3 1966</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

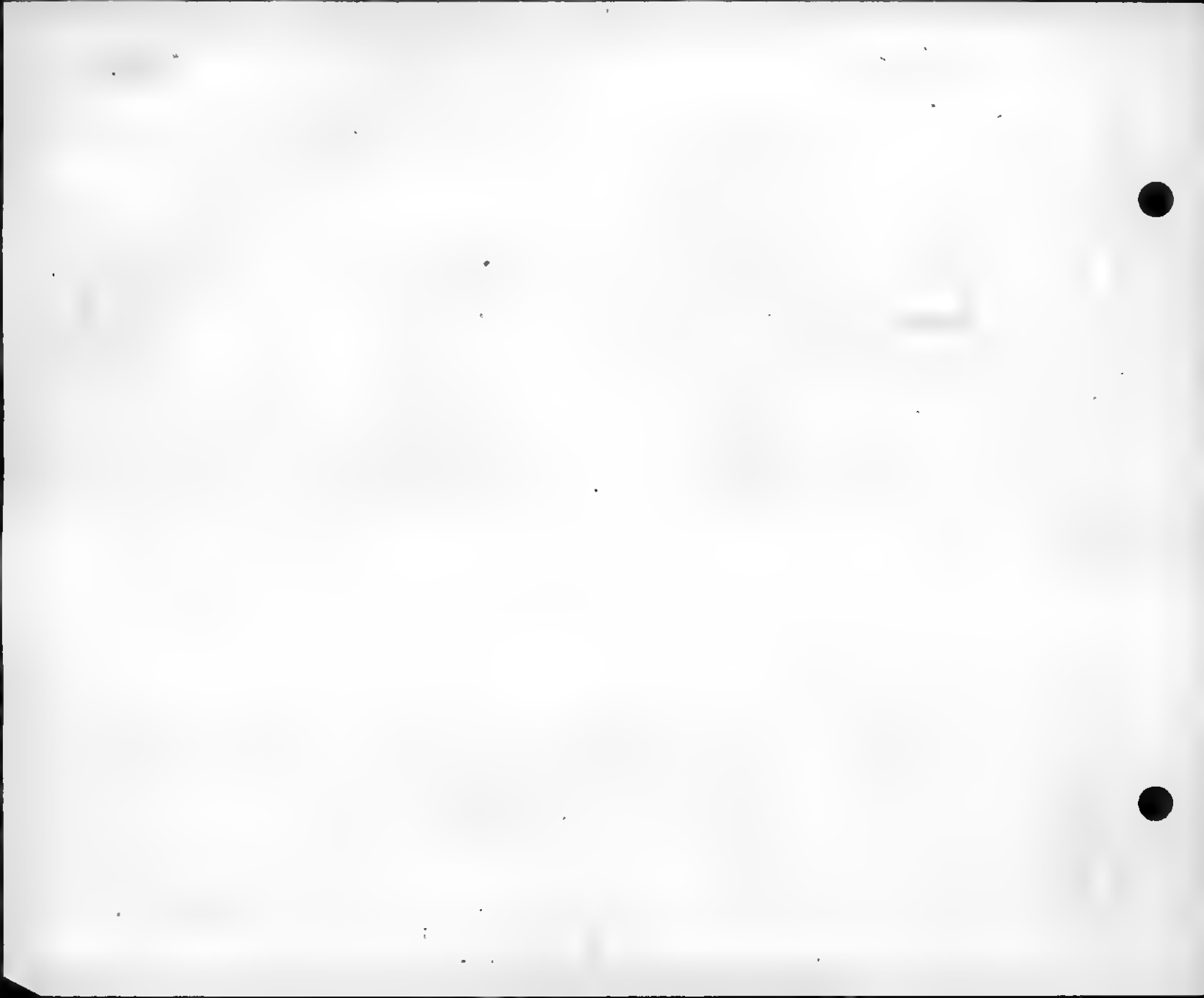
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14359

CERTIFICATE OF DEATH

14359

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>108 Williamsburg</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Green</u>				4. DATE OF DEATH Month Day Year <u>10 4 1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/66</u>		9. AGE (In years lost birthday) - yrs. <u>2</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles S. Green</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Dauphinais</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Father</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO (b) <u>Pulmonary atelectasis</u> DUE TO (c) <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10-4-1966</u> , to <u>10-4-1966</u> , that (I) (we) last saw the deceased alive on <u>10-4-1966</u> and that death occurred at <u>4:20</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>James S. Stanton</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James S. Stanton</u>				22d. ADDRESS <u>56 W. Edmonston Dr Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home Rockville, Md.</u>				RECORDED BY REGISTRAR <u>1005</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 11 1966</u>							



FOR STATE  
HEALTH DEPT.

14360

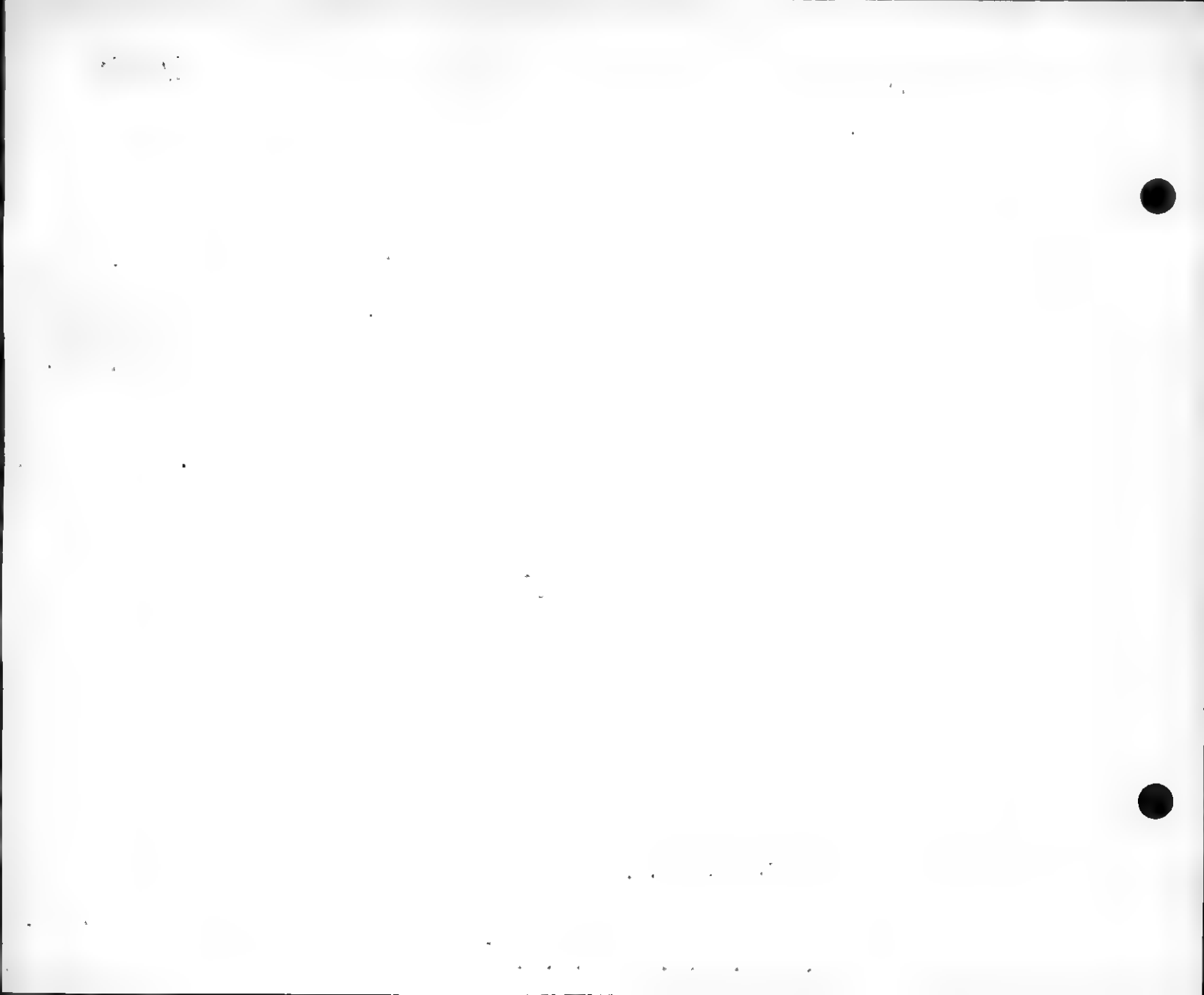
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14360

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c LENGTH OF STAY IN 1b			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>Silver Spring</del> <u>Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d STREET ADDRESS <u>7203 Rollingwood Drive</u>			
3. NAME OF DECEASED (Type or print) <u>EVERETT TEMPLE GREENSTREET</u>				4 DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>1966</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 13, 1901</u>	9 AGE (In years last birthday) <u>64</u> yrs	IF UNDER 1 YEAR Months <u>17</u> Days <u>19</u> Hours <u>66</u> Min		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Masonry Contractor</u>			10b KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>		11 BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		
12 CT ZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13 FATHER'S NAME <u>Temple Bird Greenstreet</u>				
14 MOTHER'S MAIDEN NAME <u>Buelah Allen</u>			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of serv) <u>No</u>				
16 SOCIAL SECURITY NO <u>577-07-6216</u>			17 INFORMANT <u>Everett T. Greenstreet, Jr. Rd., Ch. Ch., Md.</u>				
18 CAUSE OF DEATH (Enter only one cause per part for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Kella peritoneal hemorrhage</u> DUE TO (b) <u>Ruptured abd aortic aneurysm</u> DUE TO (c) <u>Atherosclerosis of aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 1B)				
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/18/66</u>				
			Address (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>10-20-1966</u>		23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24 FUNERAL DIRECTOR <u>Joseph Lawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>				25a REC'D BY REG STRAR <u>OCT 20 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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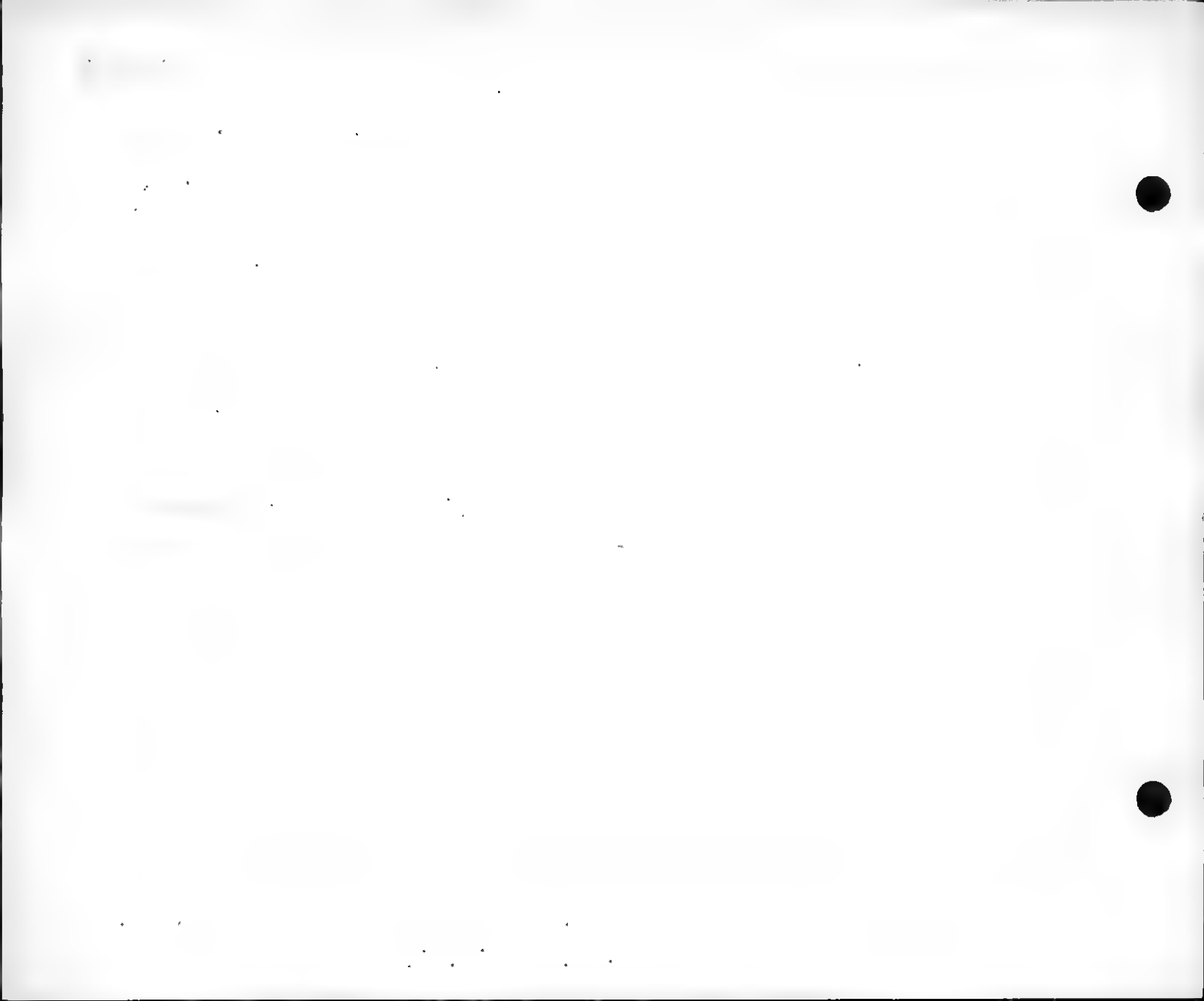
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14361

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14361

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admittance) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u>	
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY N 1b <u>Avondale</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		d STREET ADDRESS <u>4801 Russell Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Preston</u> Middle <u>Albert</u> Last <u>Guy</u>		4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1966</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1908</u>
9 AGE (In years lost, birthday) yrs. <u>68</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>P.O. Apt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Registering in P.O.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>George Guy</u>		14. MOTHER'S M.A.D.N. NAME <u>Hawkins</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>- - -</u>	
17 INFORMANT <u>Wife - Mrs. Irene - Same.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Heart Disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.		22. DATE SIGNED <u>Oct. 11, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-13-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Nat'l. Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Va.</u>	
24. FUNERAL DIRECTOR <u>Joseph Sawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>OCT 13 1966</u>	
ADDRESS <u>150 Wisc. Ave. N.W. Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

14362

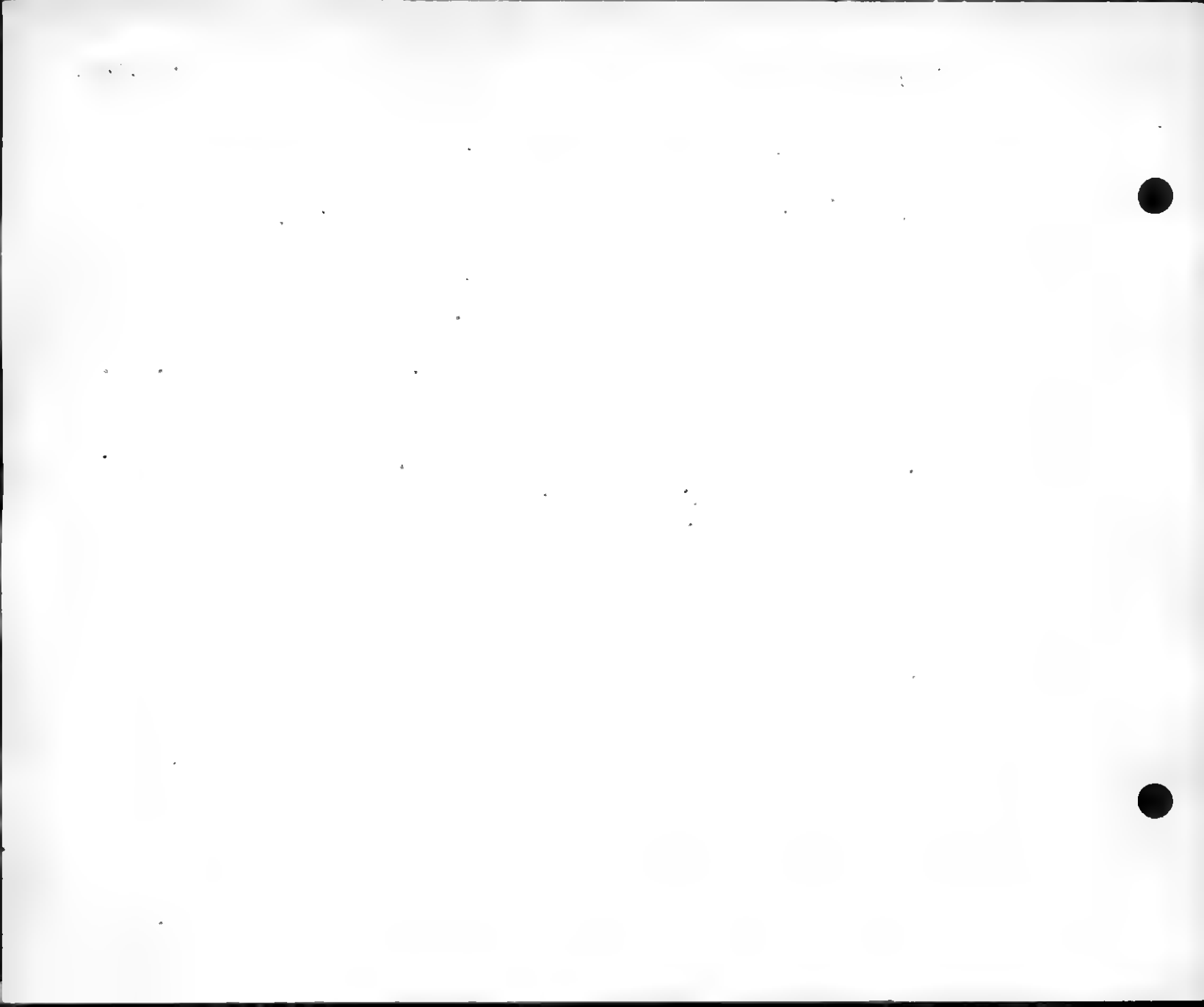
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14362

1 PLACE OF DEATH <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived for 1 year before admission) <i>Maryland</i> b COUNTY <i>Montgomery</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c LENGTH OF STAY IN 1b <i>Kensington</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>11015 Bluebell Lane</i>		d STREET ADDRESS <i>11015 Bluebell Lane</i>	
3. NAME OF DECEASED (Type or print) <i>DAVID</i> First <i>G.</i> Middle <i>HAAS</i> Last		4 DATE OF DEATH <i>10-23-66</i> 19 <i>66</i>	
5 SEX <i>M</i>	6 COLOR OR RACE <i>Cauc.</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Apr. 6, 1935</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Archivist</i>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <i>Conn.</i>		12 CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13 FATHER'S NAME <i>George P. Haas</i>		14 MOTHER'S MAIDEN NAME <i>Beatrice Suter</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes. Korean</i>		16 SOCIAL SECURITY NO <i>047-26-6646</i>	
17 INFORMANT <i>Wife</i> Address <i>Marian W. Haas Same as Item 2.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intrathoracic Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>due to gunshot wound thru heart, self inflicted.</i> DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Deceased depressed, shot self</i>	
20c TIME OF INJURY Month, Day, Year <i>10-23-66</i>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <i>Home</i>		20f (City or town) (County) (State) <i>Kensington Montgomery Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i> M.D. EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		22. DATE SIGNED <i>OCT. 24, 1966</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>10-27-66</i>	
23c NAME OF CEMETERY OR CREMATORY <i>Menonite Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Millersville, Penna</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>		25a REC'D BY REGISTRAR <i>Bethesda, Maryland</i>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>OCT 31 1966</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Cleared & Medical Examiner RSR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1



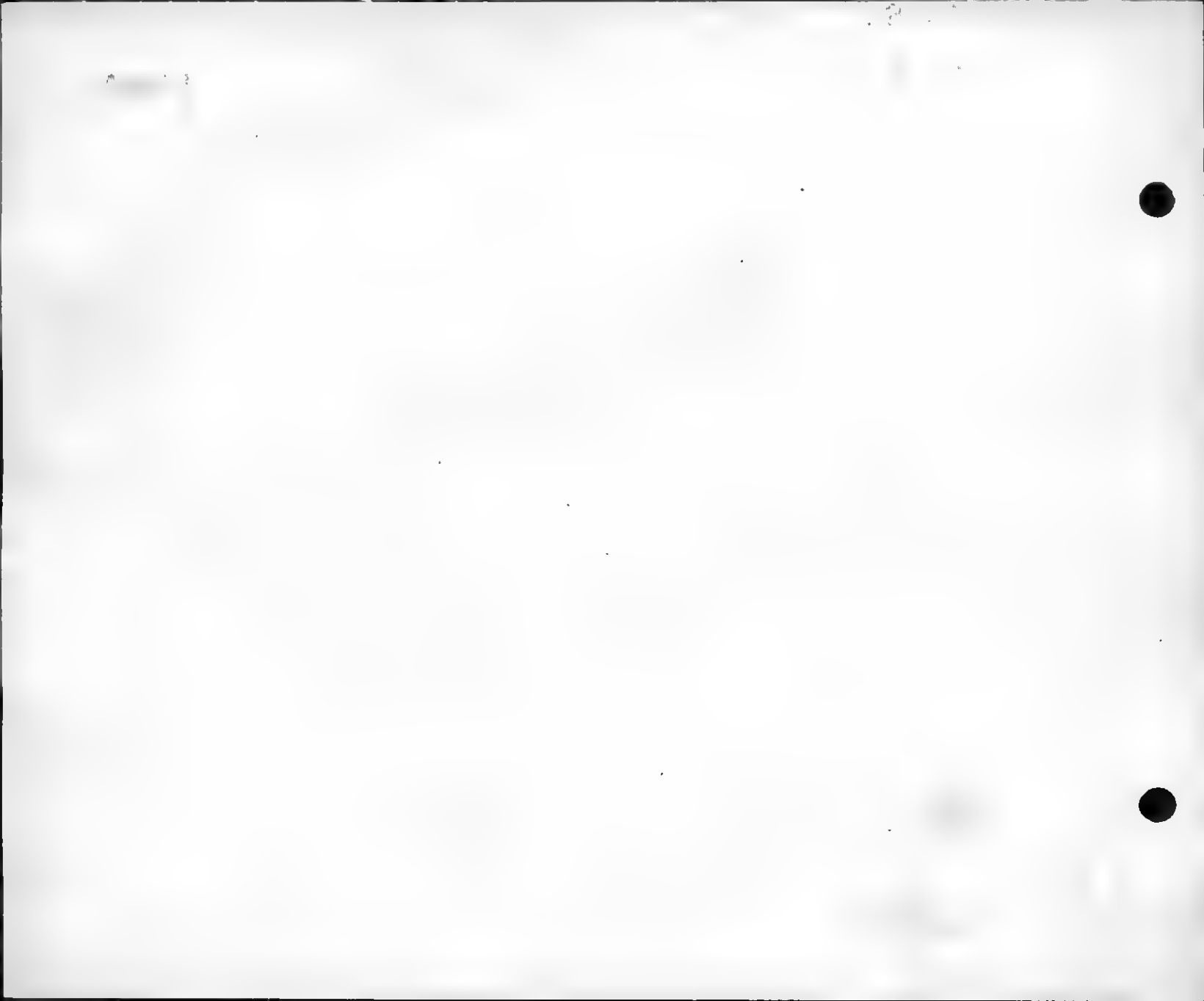
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14363

CERTIFICATE OF DEATH

14364

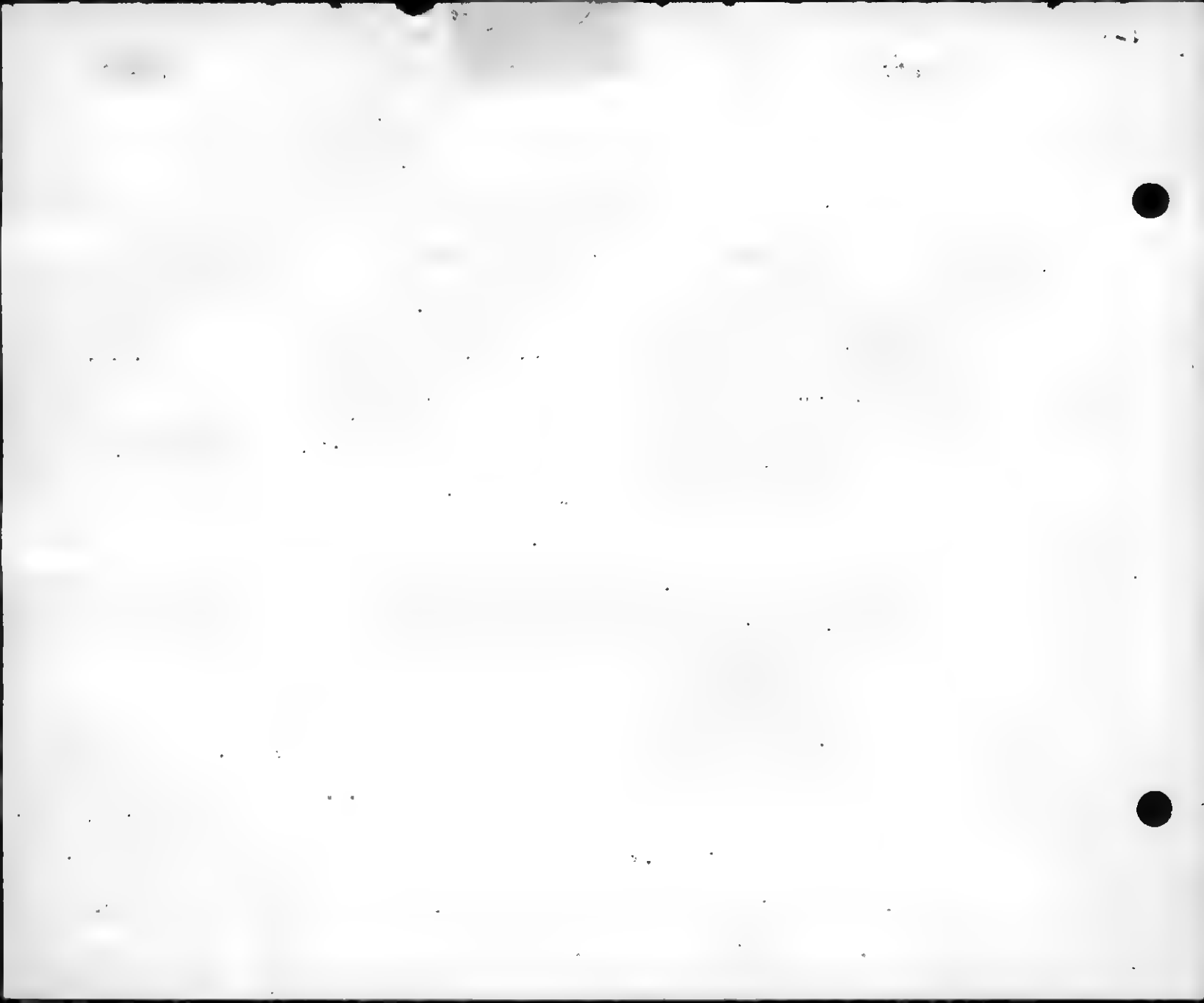
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>50 min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colesville,</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hospital</u>				d. STREET ADDRESS <u>13709 Sherwood Forest Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stella NMN Hanns</u>				4. DATE OF DEATH Month Day Year <u>10-27-1966</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Wh.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-29-1900</u>	9 AGE (In years last birthday) <u>66</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswf.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Orloski</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Golembiewski</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	17 INFORMANT Address <u>Mr. Wm. F. Hanns - Son</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic coronary vascular disease</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While or work <input type="checkbox"/> Not While or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1950</u> to <u>Oct 27, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 27 1966</u> , and that death occurred at <u>12:01 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Ronald S. Fleischer</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-27-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>RONALD S. FLEISCHER</u>				22d. ADDRESS <u>7411 RIGGS Rd HYATTSVILLE, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct 29, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Stanislaus Polish Nat</u>		23d. LOCATION (City or Town) (County) (State) <u>Scranton Pa</u>			
24. FUNERAL DIRECTOR <u>F Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>	25a. REC'D BY REGISTRAR DATE <u>OCT 31 1966</u>	25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>14364</p> </div> <div> <p>Item 1c File G-202</p> <p>11/7/66 mb</p> </div> <div> <p>14365</p> </div> </div>																																			
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b></p> <p>c. LENGTH OF STAY IN 1b <b>188</b> days</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b></p>						<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)</p> <p>a. STATE <b>Tennessee</b> b. COUNTY <b>Chattanooga</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chattanooga</b></p> <p>d. STREET ADDRESS <b>1106 South Moore Drive</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>																													
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <b>Claude</b> Middle <b>Emmitt</b> Last <b>Hardeman</b></p>			<p>4. DATE OF DEATH</p> <p>Month <b>October</b> Day <b>26</b> Year <b>1966</b></p>			<p>5. SEX <b>Male</b></p>			<p>6. COLOR OR RACE <b>White</b></p>			<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>			<p>8. DATE OF BIRTH <b>28 Sept. 1903</b></p>			<p>9. AGE (In years last birthday) <b>63</b> yrs.</p>			<p>IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b></p> <p>IF UNDER 24 HRS. <b>0</b></p>														
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b></p>						<p>10b. KIND OF BUSINESS OR INDUSTRY <b>Industrial Machine Co. Georgia</b></p>						<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Georgia</b></p>						<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>																	
<p>13. FATHER'S NAME <b>Marion Hardeman</b></p>						<p>14. MOTHER'S MAIDEN NAME <b>Loraine Brock</b></p>						<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)</p>						<p>16. SOCIAL SECURITY NO. <b>417-09-6795</b></p>						<p>17. INFORMANT <b>The Medical Record, The Clinical Center, Bethesda, Maryland</b></p>											
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomonas Septicemia</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hepatic Failure</b></p> <p>(c) <b>Acute Myelogenous Leukemia</b></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Renal Failure</b></p>												<p>INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b></p>						<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>																	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>												<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>																							
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour <b>a.m.</b> <b>19</b> p.m.</p>						<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>						<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>						<p>20f. (City or town) (County) (State)</p>																	
<p>21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>20 April</b>, 19<b>66</b>, to <b>26 Oct.</b>, 19<b>66</b>, that <b>XX</b> (we) last saw the deceased alive on <b>26 October</b>, 19<b>66</b>, and that death occurred at <b>7:55</b>, from the causes and on the date stated above.</p>																																			
<p>22a. SIGNATURE <b>Paul Neiman</b></p>												<p>22b. DATE SIGNED <b>26 October 1966</b></p>																							
<p>22c. PHYSICIAN'S NAME (Type) <b>Paul Neiman, M.D.</b></p>												<p>22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b></p>																							
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b></p>						<p>23b. DATE THEREOF <b>10-28-66</b></p>						<p>23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Cem.</b></p>						<p>23d. LOCATION (City, town or county) (State) <b>Chattanooga, Tenn.</b></p>																	
<p>24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b></p>												<p>25a. REC'D BY REGISTRAR <b>NOV 1 1966</b></p>												<p>25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b></p>											





MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

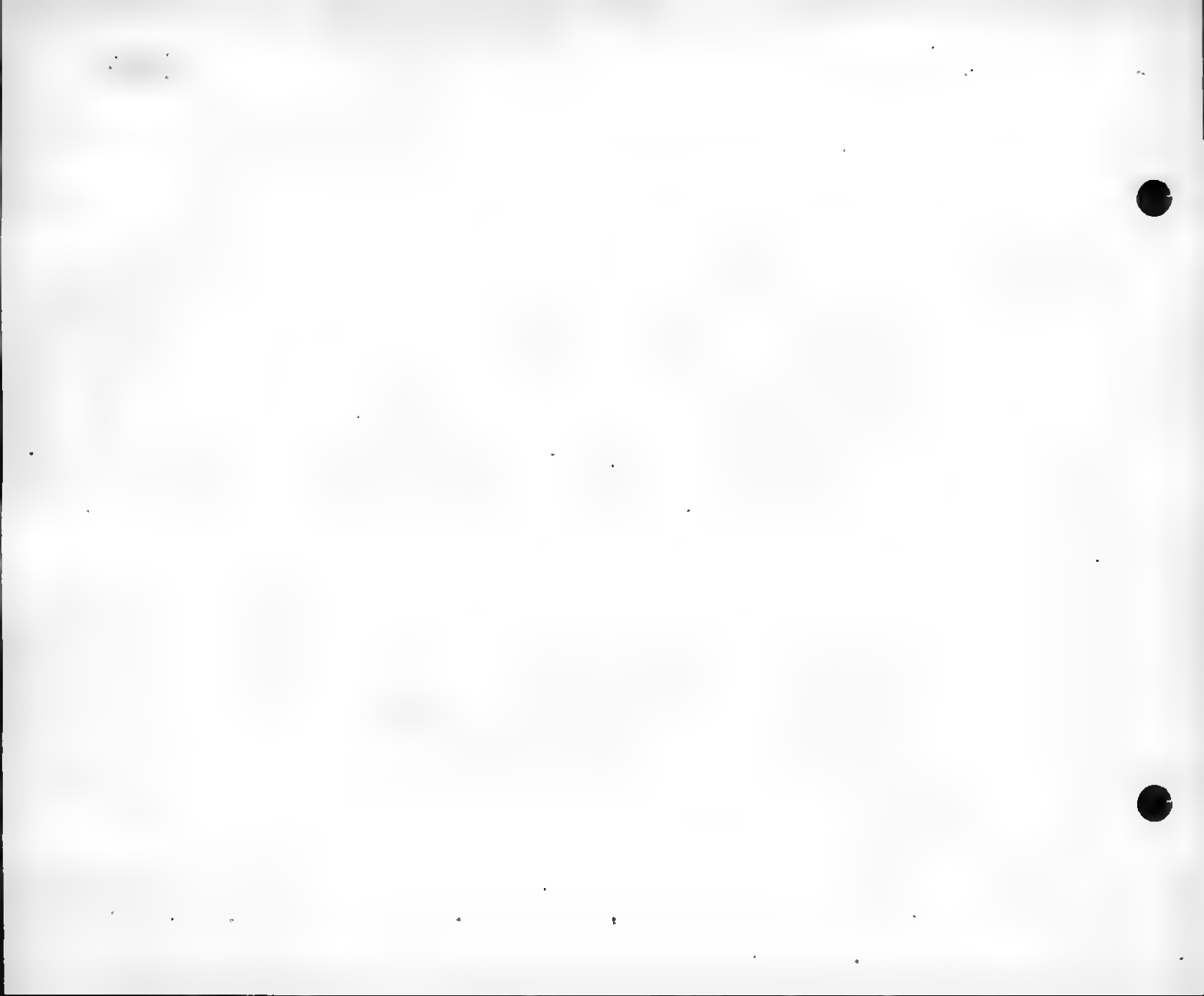
CERTIFICATE OF DEATH

14365

14366

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			c. LENGTH OF STAY in lb <u>2 1/2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CABIN JOHN</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>77 Froude Circle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KATHRYN</u> Middle <u>F.</u> Last <u>HARDY</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan - 29 - 1905</u>	
9. AGE (in years last birthday) yrs <u>61</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAT INST HEALTH</u>		11. BIRTHPLACE (County & State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Harry Fitzpatrick</u>			
14. MOTHER'S MAIDEN NAME <u>Alice O'Connor</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>579-20-8113</u>				17. INFORMANT <u>Charles Schlichter</u> Address <u>Same as Item 2.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant hypertension</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u> <u>1-2 1/2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>64</u> , to <u>10/25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>I L Marks</u>				22b. DATE SIGNED <u>10/25/66</u>		22c. PHYSICIAN'S NAME (Type) <u>I L MARKS, M.D.</u>	
22d. ADDRESS <u>370 University Blvd. E. Sec 4</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Burial-transit</u>		<u>10-28-66</u>		<u>St. Agnes Cem.</u>		<u>Menands, New York</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 31 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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1



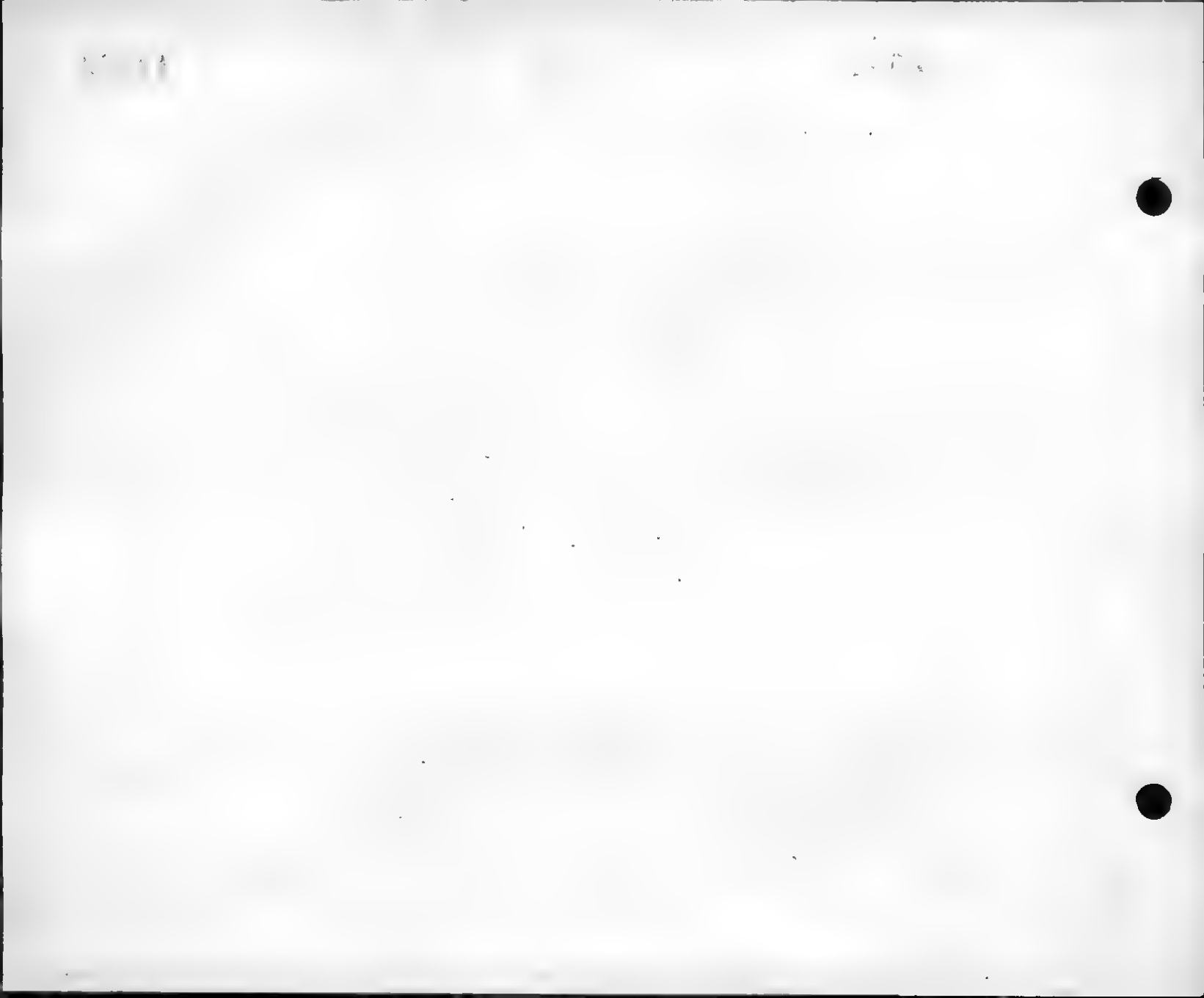
MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14366

CERTIFICATE OF DEATH

14363

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				d. STREET ADDRESS <u>521 DALE DRIVE APT #1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARL A HARMON</u> DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1966</u>							
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/00</u>	9. AGE (In years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKRY CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>		11. BIRTH PLACE (County & State, or foreign country) <u>Montgomery D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Dr. A. Harmon</u>				14. MOTHER'S MAIDEN NAME <u>Ida Baker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>574-12 9702</u>		17. INFORMANT Address <u>Bernice J. Harmon 3406 Potomac St. N.W.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bronchogenic Ca (T) lung with metastasis to thyroid gland. poss brain.</u> DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>cardiome. accident sec to a) &amp; b)</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>28 Sept., 1966</u> , to <u>28 Oct., 1966</u> , that (I) (we) last saw the deceased alive on <u>28 Oct., 1966</u> , and that death occurred at <u>5:40 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>V. de Guzman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Vicente C. de Guzman MD</u>				22d. ADDRESS <u>1234 19th N.W. Wash D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Burial</u>		<u>Oct 31 1966</u>		<u>St. Lincoln Cemetery</u>		<u>Prince Georges County Md</u>	
24. FUNERAL DIRECTOR <u>Dr. Del Funeral Home Wash DC</u>				25. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

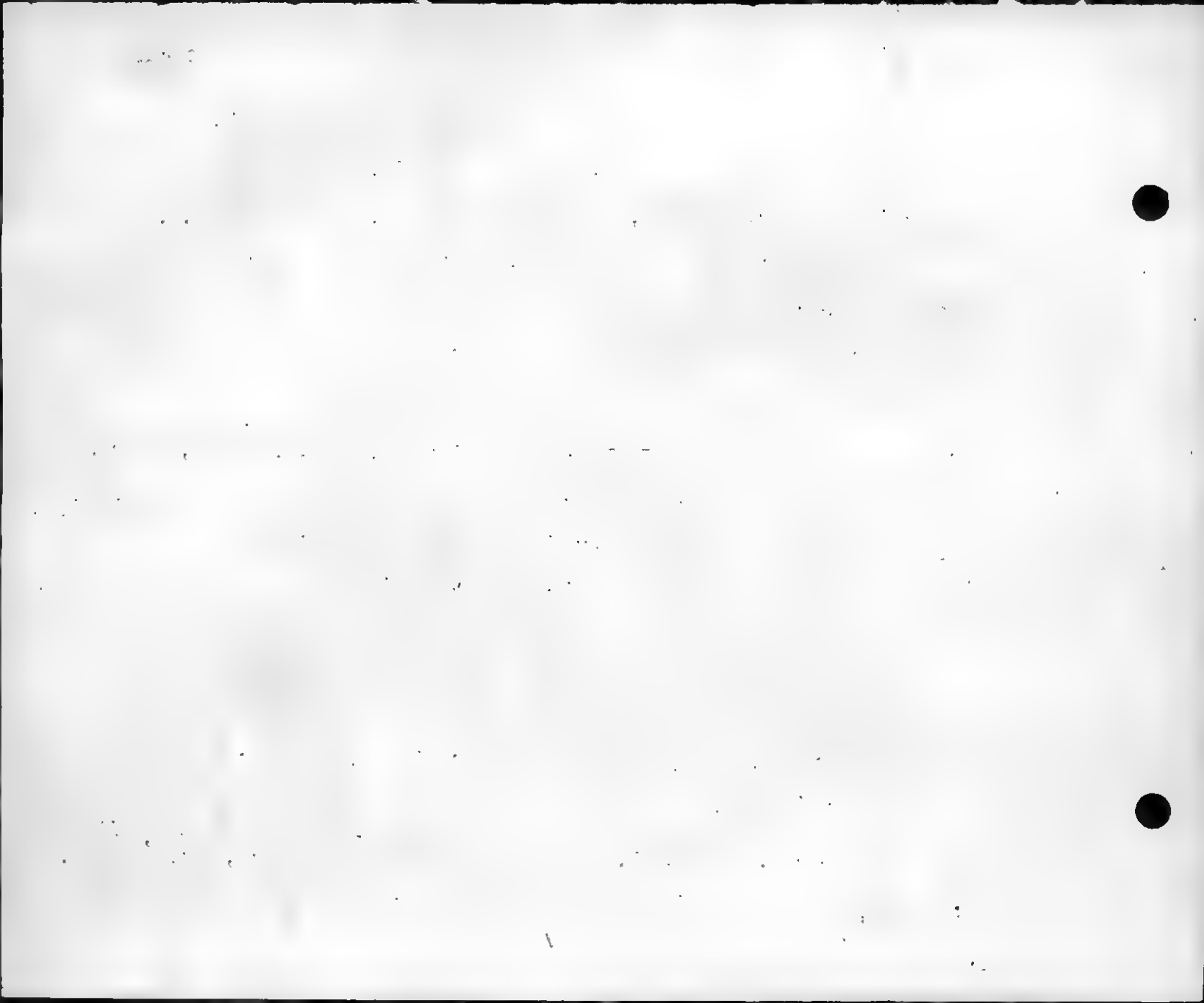


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN ID <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>800 Bellevue Street, S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary Elizabeth Henderson</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>October 5 1966</u> Month Day Year	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>16 June 1936</u>
<b>9. AGE</b> (In years last birthday) <u>30 yrs.</u> IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.		<b>10. BIRTHPLACE</b> (County & State, or foreign country) <u>District of Columbia</u> <b>11. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>12. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>13. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>14. BIRTHPLACE</b> (County & State, or foreign country) <u>District of Columbia</u> <b>15. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>16. FATHER'S NAME</b> <u>Bert Akins</u>		<b>17. MOTHER'S MAIDEN NAME</b> <u>Lois Toles</u>	
<b>18. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		<b>19. SOCIAL SECURITY NO.</b> <u>578-48-0340</u>	
<b>20. INFORMANT</b> <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda, Maryland</u>		<b>21. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> (b) <u>transformation with Renal Infiltration</u> (c) <u>Chronic Granulocytic Leukemia in Blastic /</u> (d) <u>Chronic Granulocytic Leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
<b>22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>23. INTERVAL BETWEEN ONSET AND DEATH</b> <u>8 Days</u> <u>8 Days</u> <u>2 Years</u>	
<b>24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>25. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)	
<b>26. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.	<b>27. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>28. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>29. (City or town) (County) (State)</b>
<b>30. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 21</u> , 19 <u>66</u> , to <u>Oct. 5</u> , 19 <u>66</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 5</u> , 19 <u>66</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
<b>31. SIGNATURE</b> <u>Paul E. Neiman MD</u>		<b>32. DATE SIGNED</b> <u>6 October 1966</u>	
<b>33. PHYSICIAN'S NAME (Type)</b> <u>Paul E. Neiman, MD.</u>		<b>34. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
<b>35. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>36. DATE THEREOF</b> <u>10-11-66</u>	<b>37. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat. Cemetery</u>	<b>38. LOCATION (City, town or county) (State)</b> <u>Arlington, D.C.</u>
<b>39. FUNERAL DIRECTOR</b> <u>Crouch's Funeral Home</u>		<b>40. REC'D BY REGISTRAR</b> <u>Charles Judge</u>	<b>41. REGISTRAR'S SIGNATURE</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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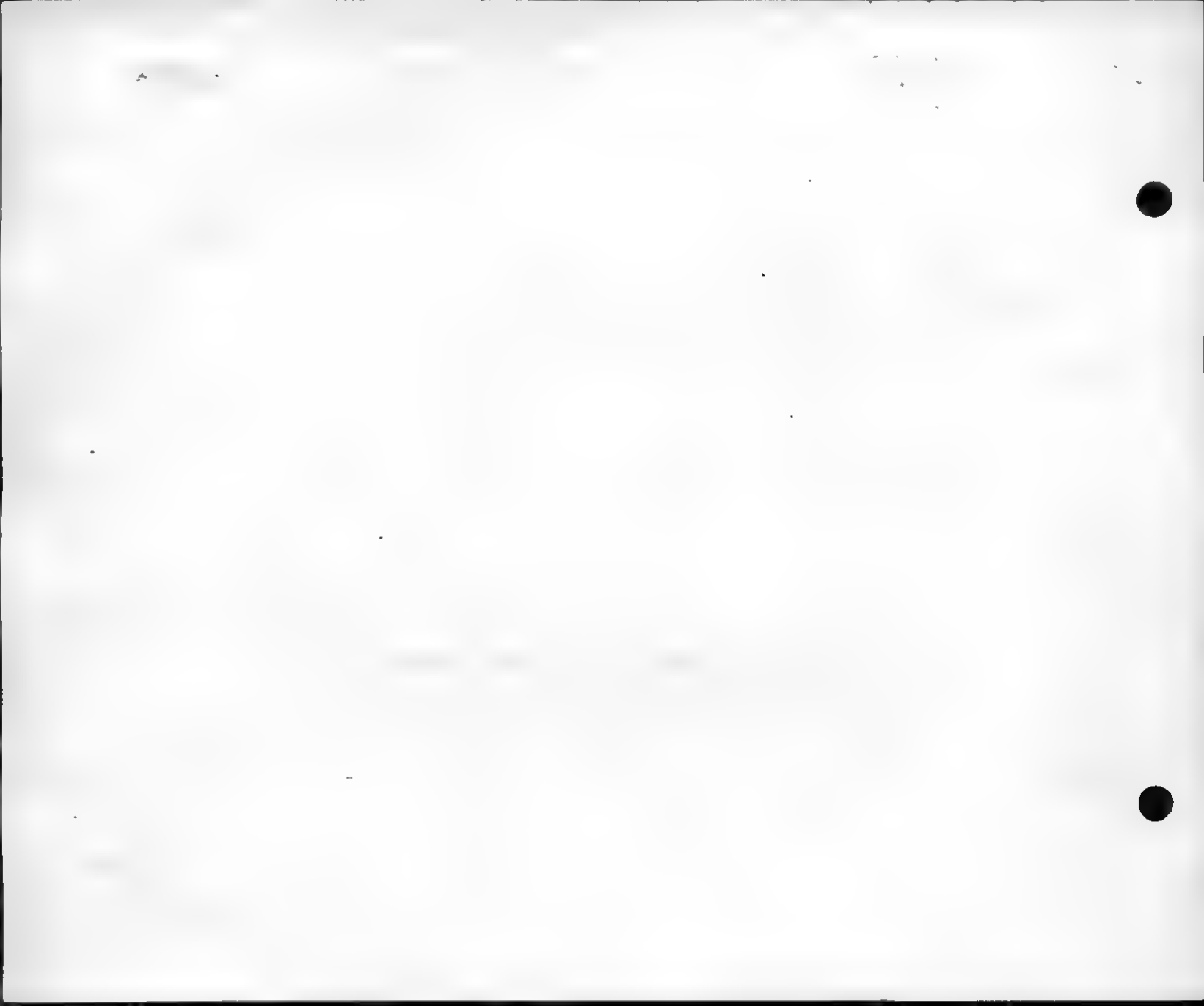
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14368

CERTIFICATE OF DEATH

14368

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN</b>				d. STREET ADDRESS <b>6312 WILSON LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RAQUEL M. HERNANDEZ</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>25</b> Year <b>1966</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/15/16</b>	9. AGE (In years last birthday) <b>50</b> yrs	IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.		IF UNDER 24 HRS Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>CAMAGÜEY, CUBA</b>		12. CITIZEN OF WHAT COUNTRY? <b>CUBA</b>	
13. FATHER'S NAME <b>ERNESTO CUESTA</b>				14. MOTHER'S MAIDEN NAME <b>RUFINA ZALDIVAR</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>266-32-7142</b>		17. INFORMANT <b>Brother</b> Address <b>Same as Item 2.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma to brain</b> DUE TO <b>Carcinoma originating in pelvis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Carcinoma originating in pelvis</b> (c) <b>2 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/16/66</b> , 1966, to <b>10/25/66</b> , 1966, that (I) (we) last saw the deceased alive on <b>10/24/66</b> , 1966, and that death occurred at <b>11:34</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Robert C. Macon</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT C. MACON</b>				22d. ADDRESS <b>809 Viers Mill Rd. Rockville</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-27-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>DATE OCT 31 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

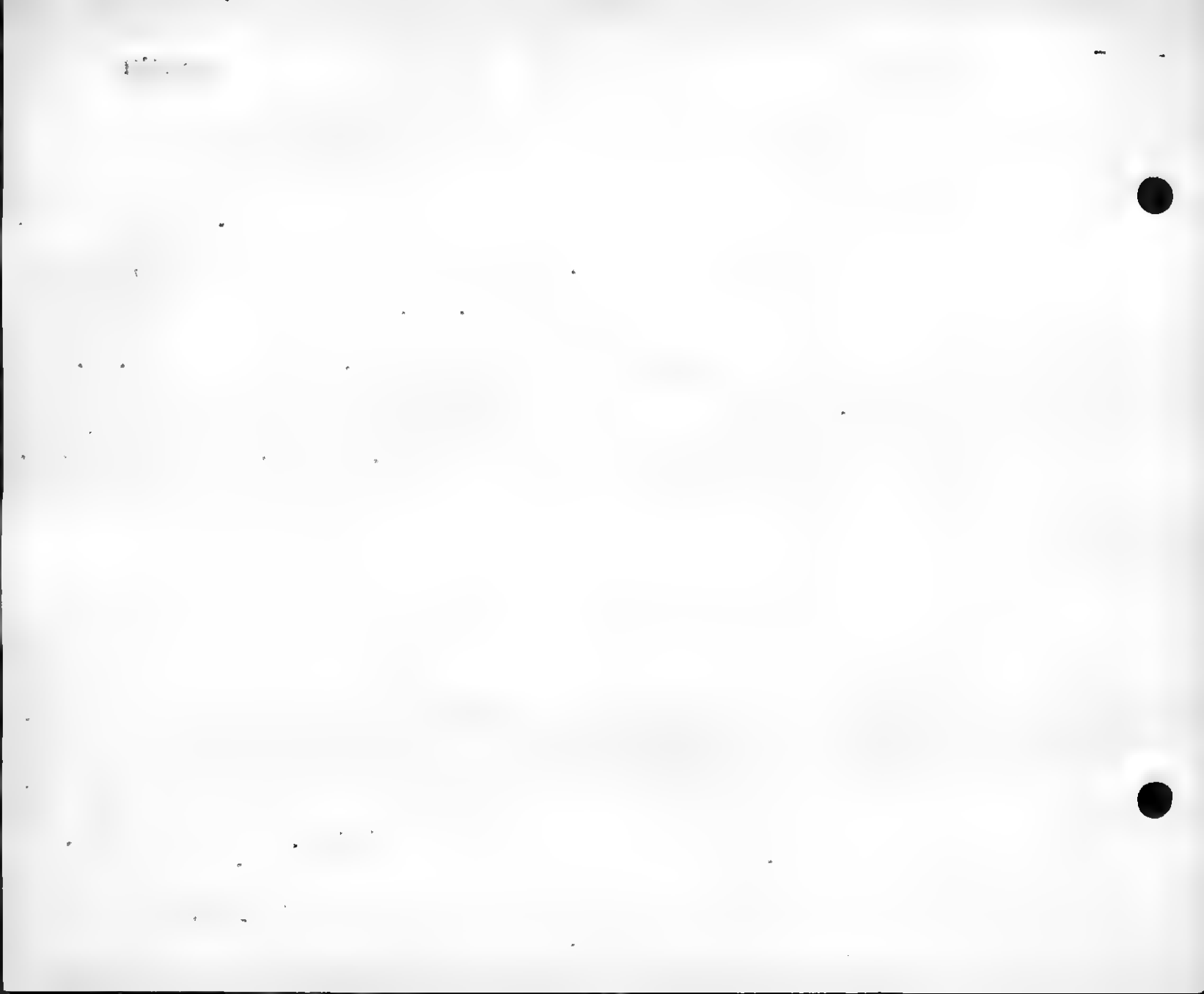
Item #21 Filed 10/20/66 pc

14369

CERTIFICATE OF DEATH

14369

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1015 DeBeck Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>LAWRENCE</b> Middle <b>A.</b> Last <b>HIGGINS</b>		4 DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Mar. 26, 1899</b>
9. AGE (in years last birthday) <b>67</b> yrs		10. IF UNDER 24 HRS Months <b>6</b> Days <b>9</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Surveyor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11 BIRTHPLACE (County & State or foreign country) <b>Rockville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Frank H. Higgins</b>		14. MOTHER'S MAIDEN NAME <b>Roberta Baker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>212-20-1084</b>	
17 INFORMANT <b>Nephew</b>		Address <b>6 Maryland Ave Franklin H. Wilson, Gaithersburg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEVERE GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (b) <b></b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 YEARS</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/14/66</b> to <b>10/15/66</b> , that (I) (we) last saw the deceased alive on <b>10/14/66</b> at <b>9:27 AM</b> , and that death occurred at <b>5:12 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W. G. Hall</b>		22b. DATE SIGNED <b>10/15/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. G. HALL</b>		22d. ADDRESS <b>615 W. Montgomery Ave. Rockville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-7-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 7 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>	



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

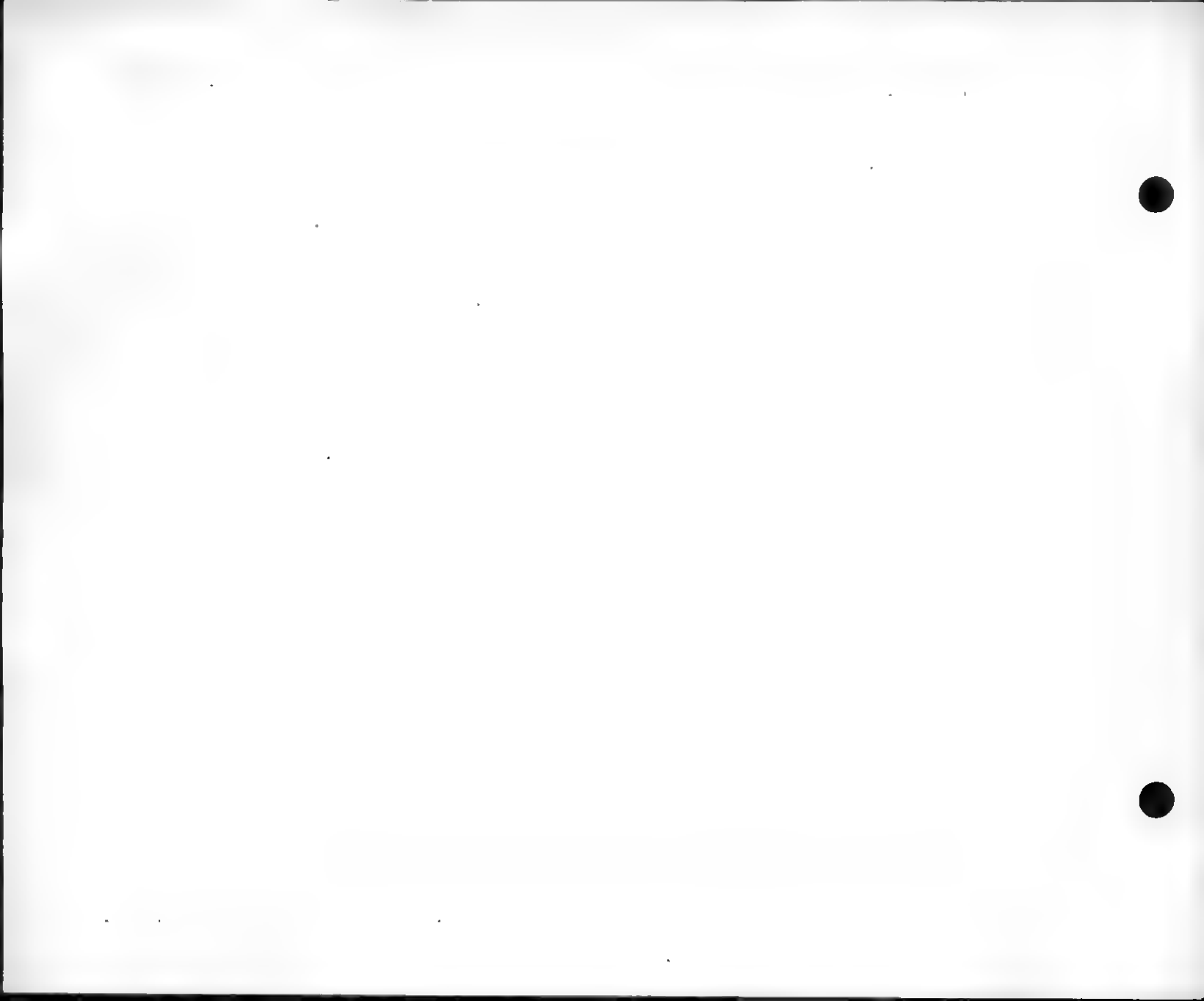
14370

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14370

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c LENGTH OF STAY IN TB <b>22 days</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ray</b> Middle <b>MON</b> Last <b>Hilton</b>		4 DATE OF DEATH Month <b>10</b> Day <b>23</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 CO. OR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/22/93</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	11 BIRTHPLACE (State or foreign country) <b>Maryland</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13 FATHER'S NAME <b>McClemen Hilton</b>	
14 MOTHER'S MAIDEN NAME <b>Catherine Molesworth</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16 SOCIAL SECURITY NO <b>213-36-8053</b>		17 INFORMANT Address <b>Hospital Records, Olney, Maryland</b>	
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute bilateral bronchopneumonia</b> DUE TO (b) <b>471A</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <b>OCT. 23, 1966</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>Oct. 26, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Meth.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Clagettville, Md.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Olin L. Molesworth, Damascus, Md.</b>	
25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14371					14371				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> Wash, D.C.				
c. LENGTH OF STAY IN 1b <u>4 yrs.</u>					d. STREET ADDRESS <u>3801 Connecticut Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Althea Woodland Nursing Home</u>					1000 Dalefield Dr N.W.				
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Lundy</u> Last <u>Holbrook</u>					4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 29, 1892</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <u>Troy, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u> Hours <u> </u> Min. <u> </u>	
13. FATHER'S NAME <u>Henry Schofield</u>					14. MOTHER'S MAIDEN NAME <u>Leitita Lundy</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>8112 Carroll Lane, Silver Spring, Maryland</u> <u>Mrs. Mary L. Kelly-Daughter-</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 321X DUE TO <u>Multiple Cerebral Vascular accidents</u> (b) <u>Arteriosclerosis and hypertension</u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Aphasia and mild right hemiplegia June 1962</u>									
19. INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u> <u>4 years</u> <u>5 yrs +</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>Oct 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sep 7/4 1966</u> , and that death occurred at <u>7a</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Stewart Clapp</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22b. DATE SIGNED <u>10.4.66</u>									
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u> 22d. ADDRESS <u>4740 Chevy Chase Dr N.W.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>									
23b. DATE THEREOF <u>10-5-66</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>									
23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>									
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Bethesda, Maryland</u>									
25a. REC'D BY REGISTRAR <u>Charles Judge</u>									
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14372

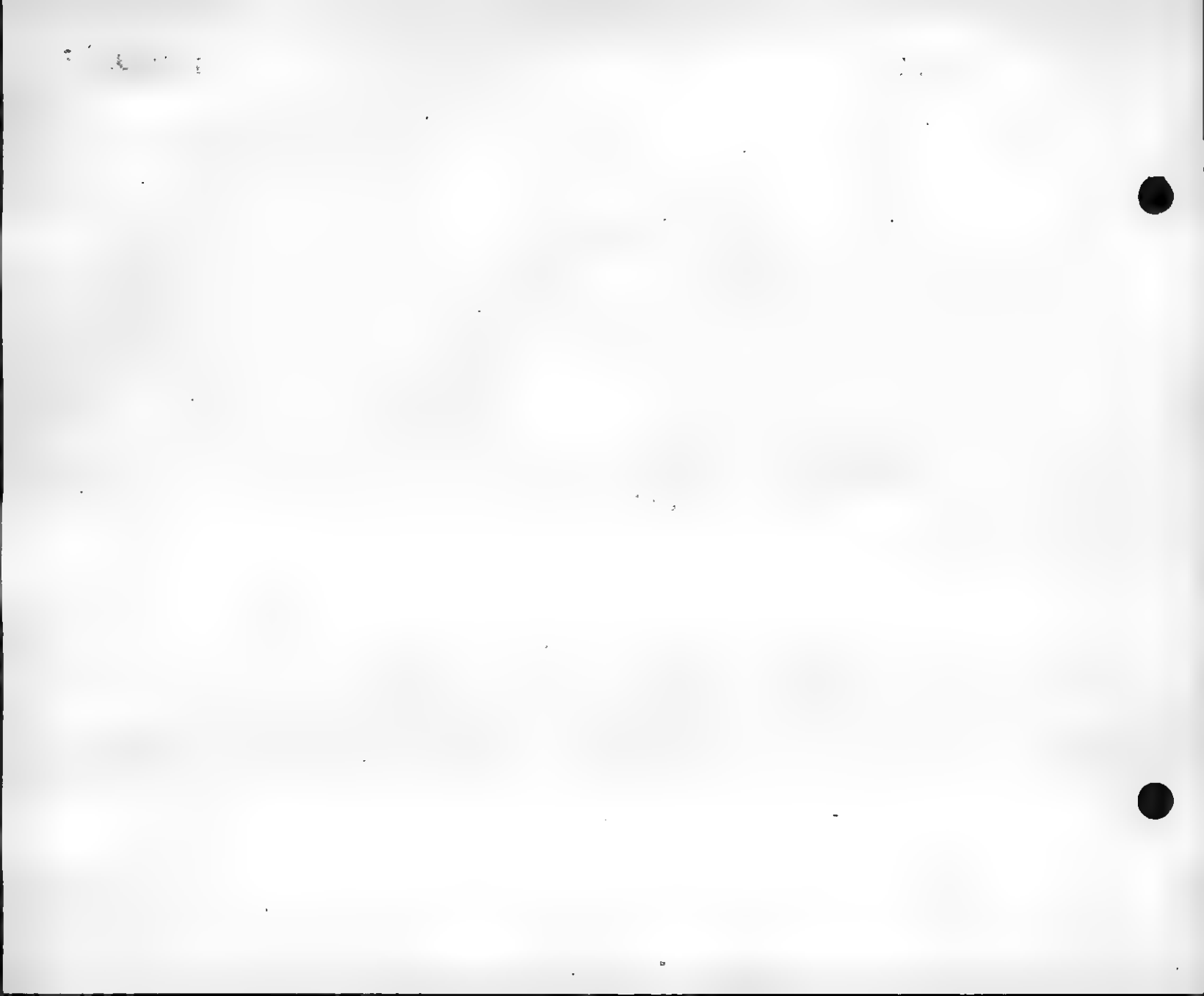
## CERTIFICATE OF DEATH

14372

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>6 days.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanatorium</u>		d. STREET ADDRESS <u>54 Wilson Road</u>	
3. NAME OF DECEASED (Type or print) <u>Collins</u> First <u>Holcomb</u> Middle <u>Holcomb</u> Last		4. DATE OF DEATH Month <u>Oct</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 23 1880</u> 9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Ret. Ins Bns</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Collins Holcomb Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Maria HUNTOON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>SPANISH AMERICAN</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. E.E. CHRISTENSEN</u> Address <u>54 Wilson Rd. ANNAPOLIS MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASHD c Heart Block</u> DUE TO (b) <u>2 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-4</u> , 19 <u>66</u> , to <u>10-10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-10</u> , 19 <u>66</u> , and that death occurred at <u>10</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>D. J. Sengstack M.D.</u>		22b. DATE SIGNED <u>10-10-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, VA</u>
24. FUNERAL DIRECTOR <u>EVES FUNERAL HOME</u> ADDRESS <u>2847 Wilson Blvd. ARLINGTON, VIRGINIA</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 13 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14373

14373

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN ID <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Green Acres</u> d. STREET ADDRESS <u>5009 MALDEN DR.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marie G. Holinger</u> First Middle Last		4. DATE OF DEATH <u>Oct. 10, 1966</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16 1906</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash - D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward R. Greer</u>		14. MOTHER'S MAIDEN NAME <u>Maria -</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Emil H. Holinger - See Item #2.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Metastatic</u> <u>144X</u> DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Cancer of Mouth</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		22. DATE SIGNED <u>Oct. 10, 1966</u> DEPUTY MEDICAL EXAMINER <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-13-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> 5130 Wisconsin Ave. N.W. Wash. DC.		25a. REC'D BY REGISTRAR <u>OCT 13 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg, Md.</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. STREET ADDRESS <b>311 South Frederick</b>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna T. Hollander</b>		4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>1966</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>White</b>		7. MARIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10-24-38 1874</b>		9. AGE (In years last birthday) <b>91</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H. Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Jefferson Co., Iowa</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Jacobson</b>		14. MOTHER'S MAIDEN NAME <b>Christina Louisa</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs. Bernice Foster</b>		Address <b>Same as 2</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>CORONARY THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 YEARS</b> <b>30 YEARS</b> <b>30 DAYS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC RENAL FAILURE CONGESTIVE HEART FAILURE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 25, 1966</b> to <b>OCTOBER 12, 1966</b> that (I) <b>(not)</b> last saw the deceased alive on <b>OCTOBER 6, 1966</b> , and that death occurred at <b>12</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Gordon S. Rosenberger</b>		22b. DATE SIGNED <b>OCT 11 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b>		22d. ADDRESS <b>310 WEST MONTGOMERY AVE. ROCKVILLE, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>10-11-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Sweden Cemetery</b>		23d. LOCATION (City, town or county) <b>Jefferson County, Iowa</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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14375

## CERTIFICATE OF DEATH

Reg. Dist. No.

14375

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9716 Parkwood Drive</b>		d. STREET ADDRESS <b>9716 Parkwood Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>KATHARINE</b> Middle <b>L.</b> Last <b>HOLLISTER</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>3,</b> Year <b>19 66</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1895</b>
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Harry Lawder</b>		14. MOTHER'S MAIDEN NAME <b>Dora Crampton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Husband</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Cerebral Vascular accidents</b> DUE TO <b>Subacute combined degeneration of cord</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Spondyl</b> DUE TO <b>Cause undetermined</b> (c) <b>5 yrs +</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL-EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> to <b>Oct 3</b> , 1966, that I last saw the deceased alive on <b>Oct 3</b> , 1966, and that death occurred at <b>6:45 p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stewart Clapp</b> M.D.		ADDRESS (Street, city or town, state) <b>4740 Chevy Chase Dr</b> DATE SIGNED <b>10-3-66</b>	
PHYSICIAN'S NAME (Type) <b>Stewart Clapp MD</b>		<b>Chevy Chase Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>	22b. DATE THEREOF <b>10/7/1966</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Troy New York</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 7 1966</b>		24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

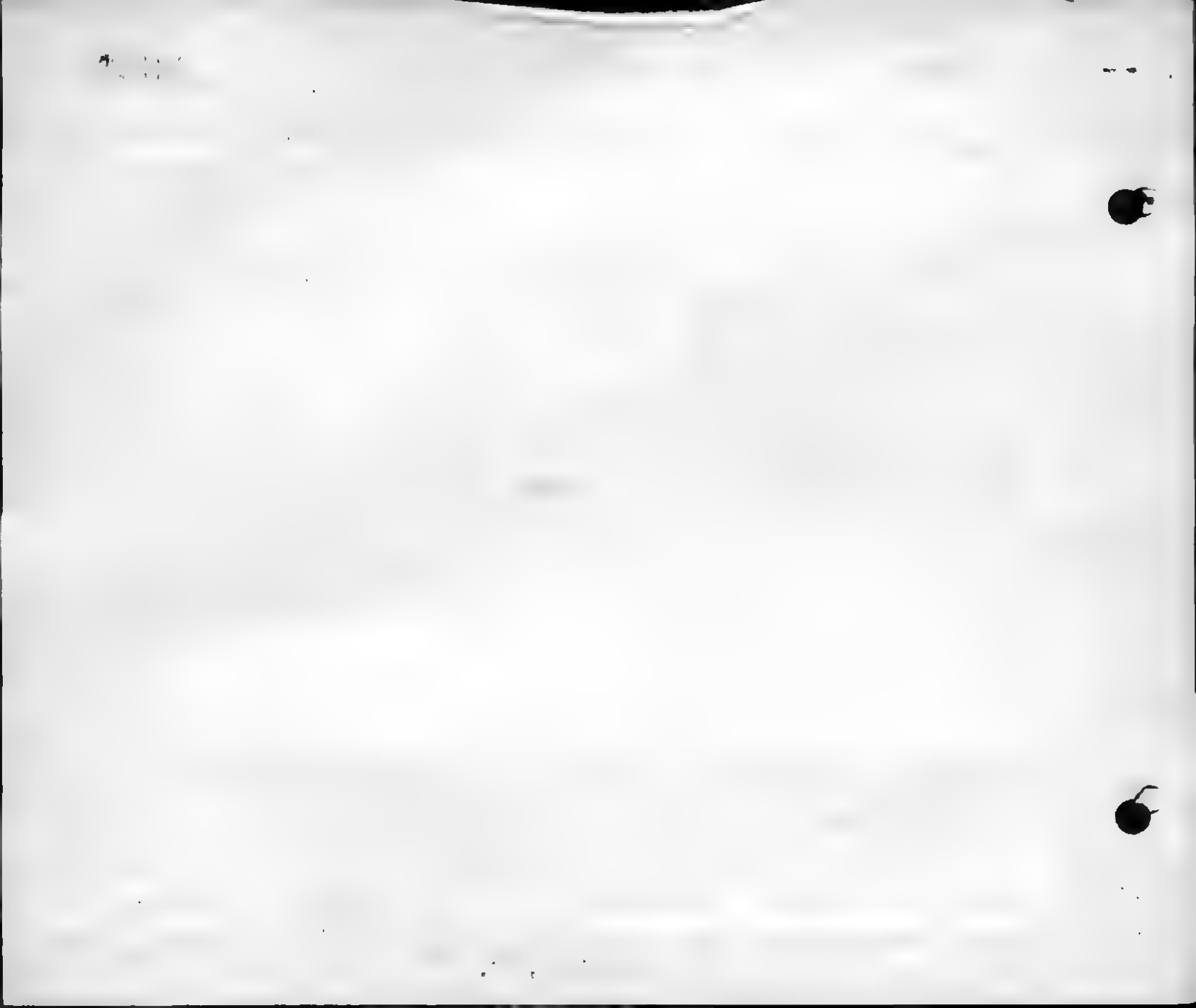
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14376

14376

1. PLACE OF DEATH & COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN IL <i>26 hrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>916 Viewmill Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Elyahuta L. Holt</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>15</i> Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/23/09</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gov. worker</i>	
13. FATHER'S NAME <i>Eugene L. Bouteaux</i>		14. MOTHER'S MAIDEN NAME <i>Mary Becker</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>AC</i>		16. SOCIAL SECURITY NO. <i>577-10-4234</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circumstances of the heart, with generalized metastasis.</i> DUE TO (b) <i>metastasis.</i> DUE TO (c) <i>(Right) leading metastatic March 1965</i>		INTERVAL BETWEEN ONSET AND DEATH <i>about 2 years.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1959</i> to <i>Oct 15, 1966</i> , that (I) <del>was</del> last saw the deceased alive on <i>Oct 14, 1966</i> , and that death occurred <i>8:55 AM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>W. A. Linthicum</i>		22b. DATE SIGNED <i>10/17/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. A. Linthicum</i>		22d. ADDRESS <i>110 S. Washington St. Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10/18/66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>		23d. LOCATION (City, town or county) (State) <i>Rockville Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler Funeral Home</i>		25a. REC'D BY REGISTRAR <i>Oct 18 1966</i>	
ADDRESS <i>1331 Rockville Pike Rockville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. It is to be used with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

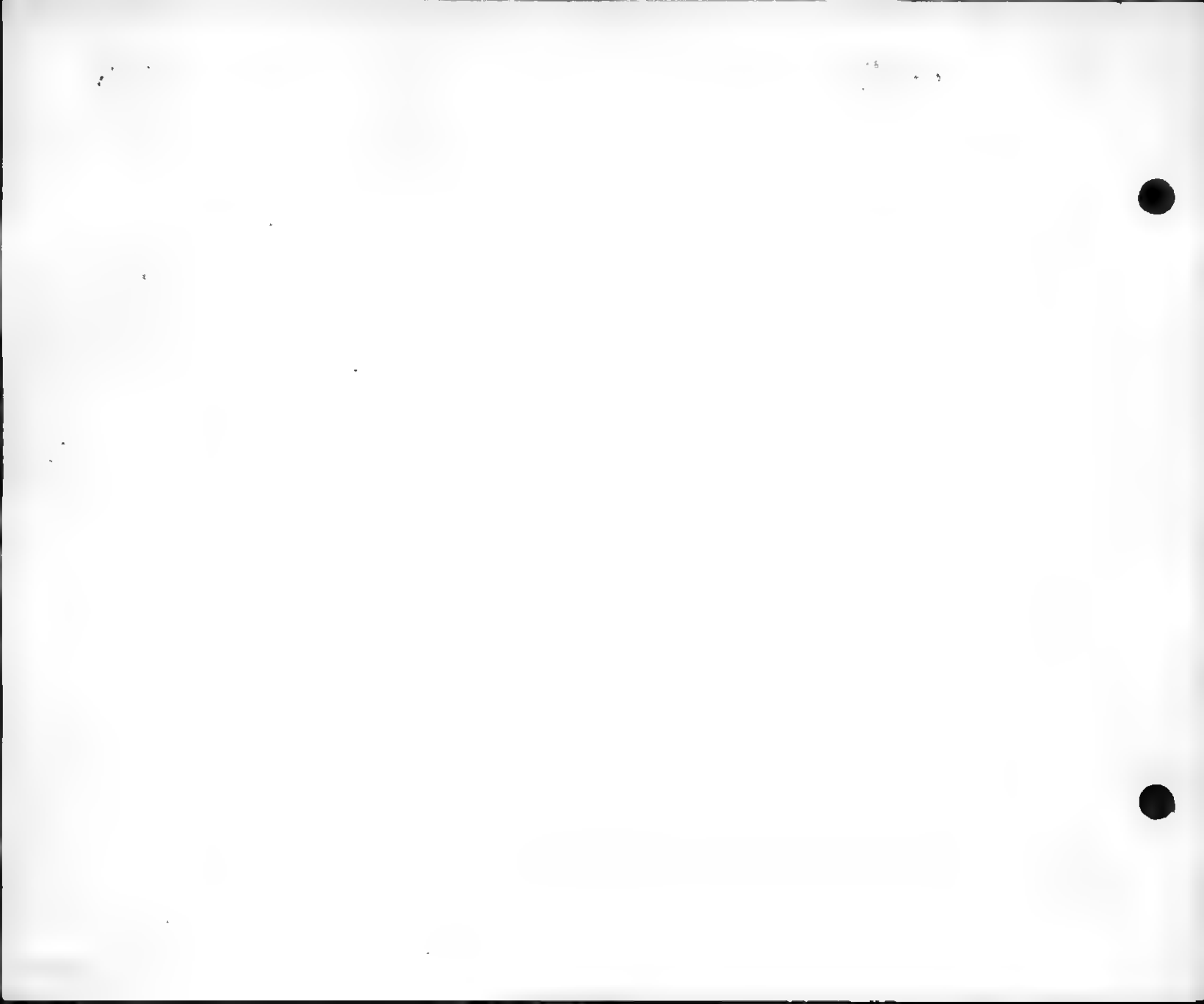
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14377

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14377

1 PLACE OF DEATH a COUNTY <b>Montgomery County</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c LENGTH OF STAY N 1b <b>5 days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		e STREET ADDRESS <b>14632 Peach Orchard Road</b>	
3 NAME OF DECEASED (Type or print) First <b>Hans</b> Middle <b>E.</b> Last <b>Hoppensack</b>		4 DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 CO. OR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10/30/89</b>
9 AGE (In years last birthday) <b>77</b> yrs		10 UNDER 1 YEAR F UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Accountant</b>		10b KIND OF BUSINESS OR INDUSTRY <b>German Govt.</b>	
11 BIRTHPLACE (State or foreign country) <b>Germany</b>		12 CITIZEN OF WHAT COUNTRY? <b>Germany</b>	
13 FATHER'S NAME <b>Otto Hoppensack</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>220-48-9698</b>	
17 INFORMANT <b>Mrs. Martha Hoppensack</b>		14632 Peach Orchard Rd. <b>Silver Spring, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute intracranial hemorrhage</b> DUE TO (b) <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Read</b> M.D.		22. DATE SIGNED <b>10/31/1966</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. READ M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Nov. 3, 1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Burtonsville Union Cemetery</b>	23d LOCATION (City or town) (County) (State) <b>Burtonsville, Maryland</b>
24 FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Humphrey, Inc.</b>		25a REC'D BY REGISTRAR <b>Charles Judge</b> 25b REGISTRAR'S SIGNATURE <b>10/31/1966</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

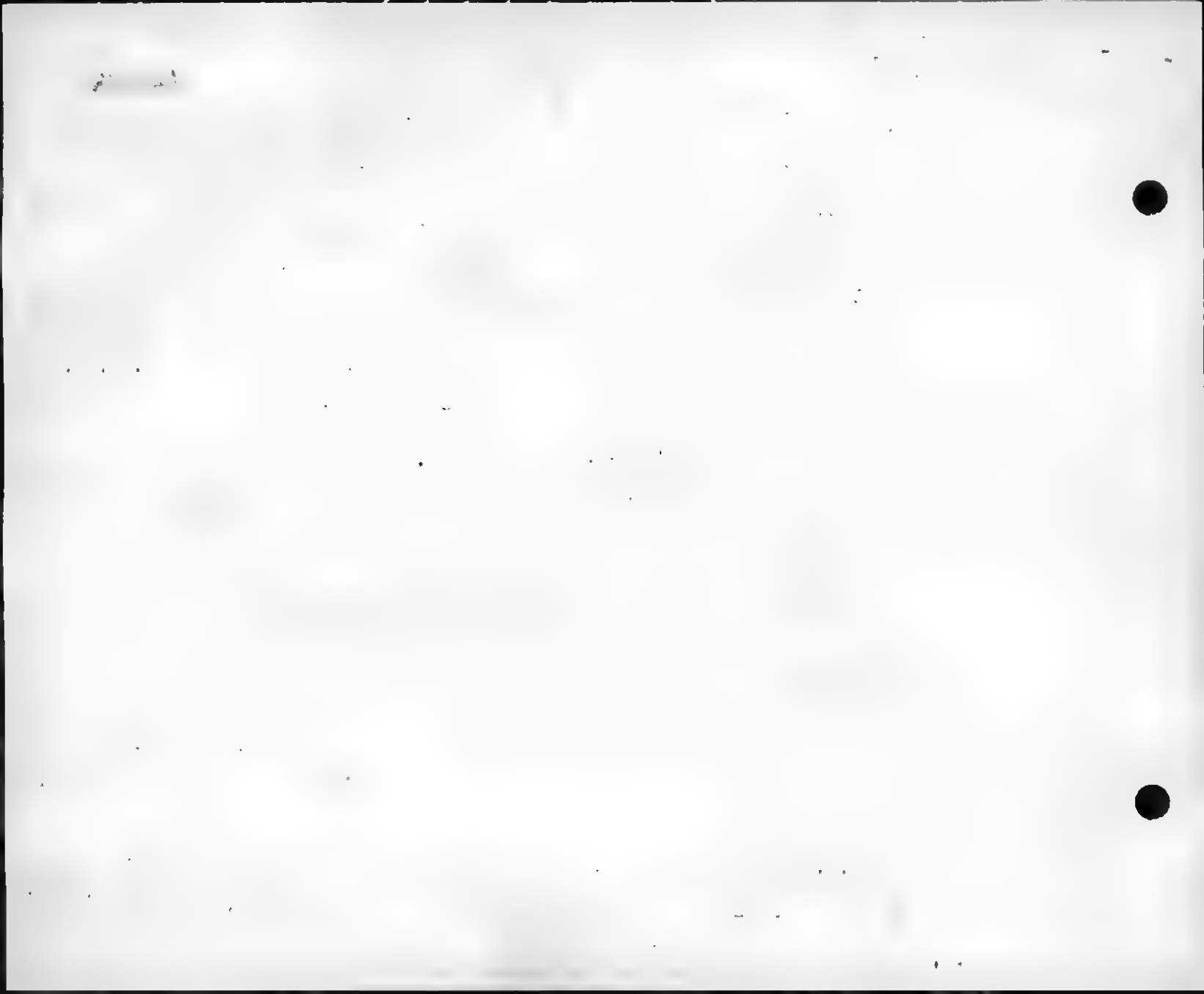
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 21 Film 6782 11/7/66 mh

14378

CERTIFICATE OF DEATH

14378

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>3 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> d. STREET ADDRESS <b>10201 GROSVENOR PLACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Budhi Howard HUBBELL</b>		4. DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 7, 1912</b>
9. AGE (n years last birthday) <b>54 yrs</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>Floesville, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis Howard</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Virginia Gray</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>557-05-8082</b>	
17. INFORMANT <b>Charles W. Hubbell</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LUNG CARCINOMA WITH METASTASE TO MEDIASTINUM</b> <b>165 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>AND SKULL</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5 OCT</b> , 19 <b>66</b> , to <b>8 OCT</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>8 OCT</b> , 19 <b>66</b> , and that death occurred at <b>7:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>M.G. Andersen</b>		22b. DATE SIGNED <b>7:40 AM</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.G. ANDERSEN, CDR, MC, USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-12-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 11 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. Edge</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Card with medical examiner

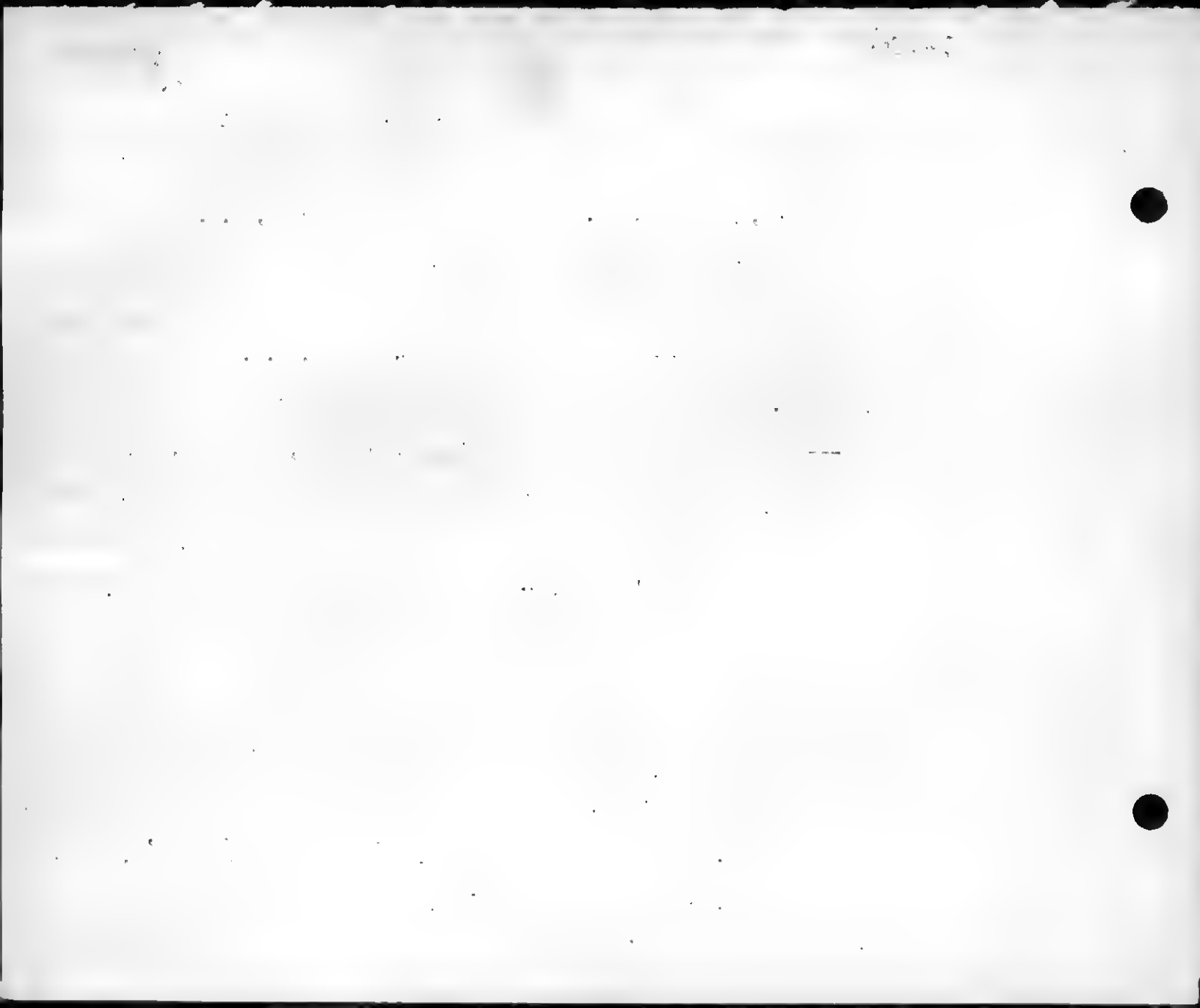
<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			<b>c. LENGTH OF STAY IN 1b</b> <b>9 hours</b>		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <b>Holy Cross Hospital</b>					<b>d. STREET ADDRESS</b> <b>12305 Tretoria Drive</b>			<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>David</b> Middle <b>A.</b> Last <b>Hughes</b>					<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>25</b> , Year <b>19 66</b>				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 13, 1955</b>		<b>9. AGE</b> (In years last birthday) <b>11</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Child</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D.C.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Richard F. Hughes</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Wirth</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Hospital records Silver Springs, Md.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral degeneration</b> DUE TO (b) <b>Hurker's Syndrome</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c)									<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II or Item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1959</b> , 19 <b>66</b> , to <b>10/25</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10/25</b> , 19 <b>66</b> , and that death occurred at <b>7</b> P.M. from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <i>Murray Paul</i>								<b>22b. DATE SIGNED</b> <b>10/25/66</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>MURRAY PAUL</b>				<b>22d. ADDRESS</b> <b>Silver Springs, Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>10/28/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington, Md.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>F. Kracke sons Hyattsville Md</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>OCT 27 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>			

ST. JOHN'S B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14380 CERTIFICATE OF DEATH 14380									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>					d. STREET ADDRESS <u>114 Varnum Street, N.E.</u>				
3. NAME OF DECEASED (Type or print) First <u>Patrick</u> Middle <u>Kevin</u> Last <u>Hughes</u>			4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>19 66</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6 November 1956</u>		9. AGE (in years last birthday) <u>9</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Patrick E. Hughes</u>					14. MOTHER'S MAIDEN NAME <u>Virginia Edwards</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dehydration</u> DUE TO (c) <u>Hurler's Syndrome</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
INTERVAL BETWEEN ONSET AND DEATH <u>24 Hours</u> <u>24 Hours</u> <u>9 1/2 Years</u>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 26, 19 66</u> , to <u>October 26, 19 66</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 26, 19 66</u> , and that death occurred at <u>1130M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Joseph H. Zelson</u> M.O. <u>P</u>					22b. DATE SIGNED <u>27 October 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>Joseph H. Zelson, MD</u>					22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Oct 31, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>			
24. FUNERAL DIRECTOR <u>Janet H. Haller, 254 Carroll St NW Wash DC</u>					25a. REC'D BY REGISTRAR <u>DATE OCT 31 1966</u>				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				





MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

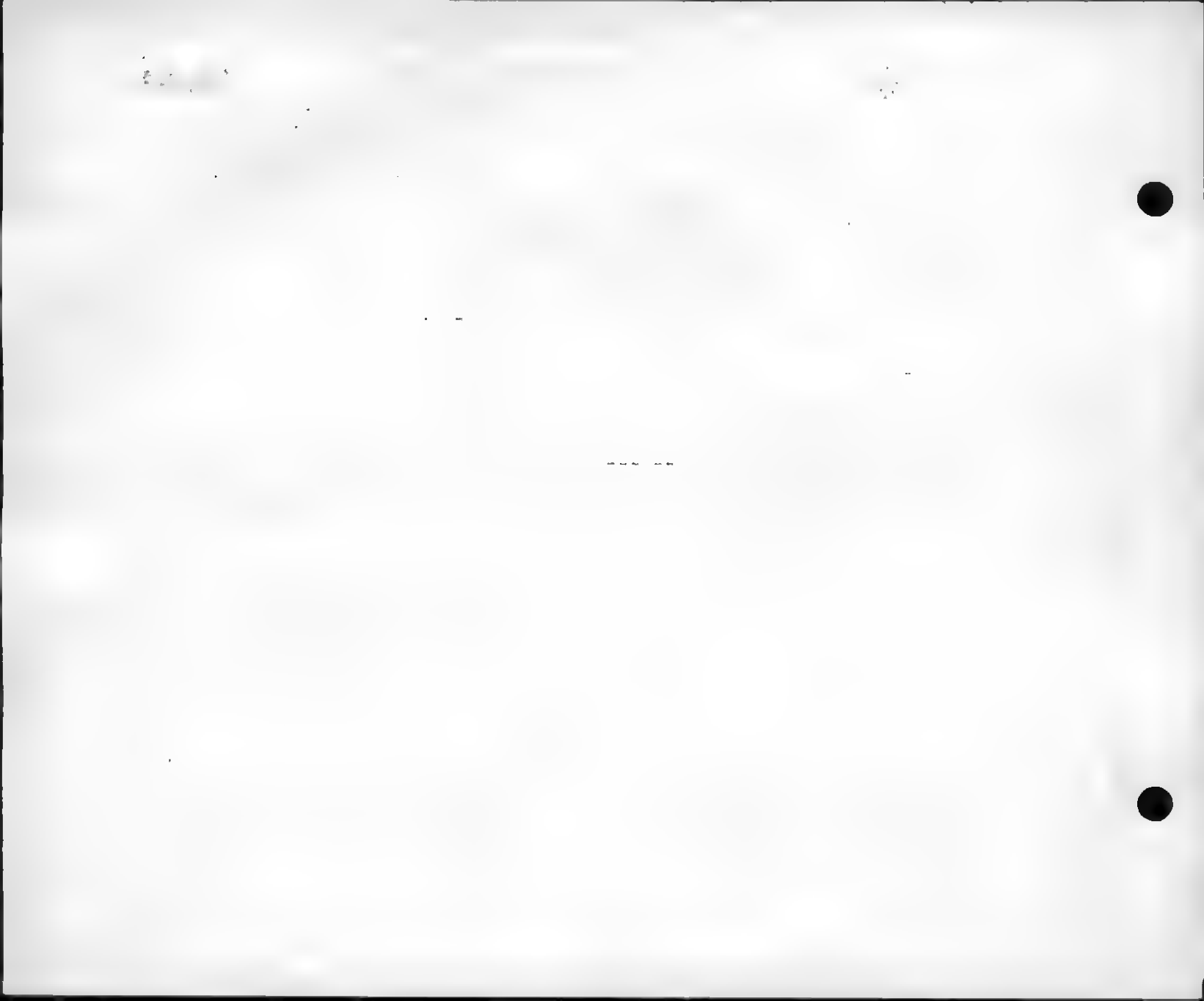
14381

14381

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>12701 Springtree Dr.</b> <b>Silver Spring, Md. Montgomery Cy.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Maryland</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Colonial Villa, 12325 New Hampshire Ave</b>		e. STREET ADDRESS <b>12701 Springtree Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>SHANNON</b> Last <b>Humphrey</b>		4. DATE OF DEATH Month <b>10</b> Day <b>2</b> Year <b>19 66</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-13-49</b>
9. AGE (In years last birthday) <b>16</b> yrs.		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>16</b> Hours <b>16</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		12. KIND OF BUSINESS OR INDUSTRY <b>HIGH SCHOOL</b>	
13. FATHER'S NAME <b>James I. Humphrey, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Hyman, Ann Mary</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>James I. Humphrey Sr.</b>		Address <b>Same as #2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca. of testicle (Mixed Teratoma)</b> 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 1966, to <b>10/2</b> , 1966, that (I) (we) last saw the deceased alive on <b>10/2</b> , 1966, and that death occurred at <b>11:45</b> A.M. from causes and on the date stated above.			
22a. SIGNATURE <b>G. Leonard Gold</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>10/2/66</b>
22c. PHYSICIAN'S NAME (Type) <b>G. Leonard Gold</b>		22d. ADDRESS <b>8641 Colesville Rd., S.I. Spring, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>10/5/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEM</b>	23d. LOCATION (City or Town) (County) (State) <b>SILVER SPRING, MONTGOMERY, MD</b>
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS, Inc</b>		ADDRESS <b>SILVER SPRING, MD</b>	25a. REC'D BY REGISTRAR <b>OCT 5 1966</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Items #2c & d from #G381 10/10/66 pc

14382

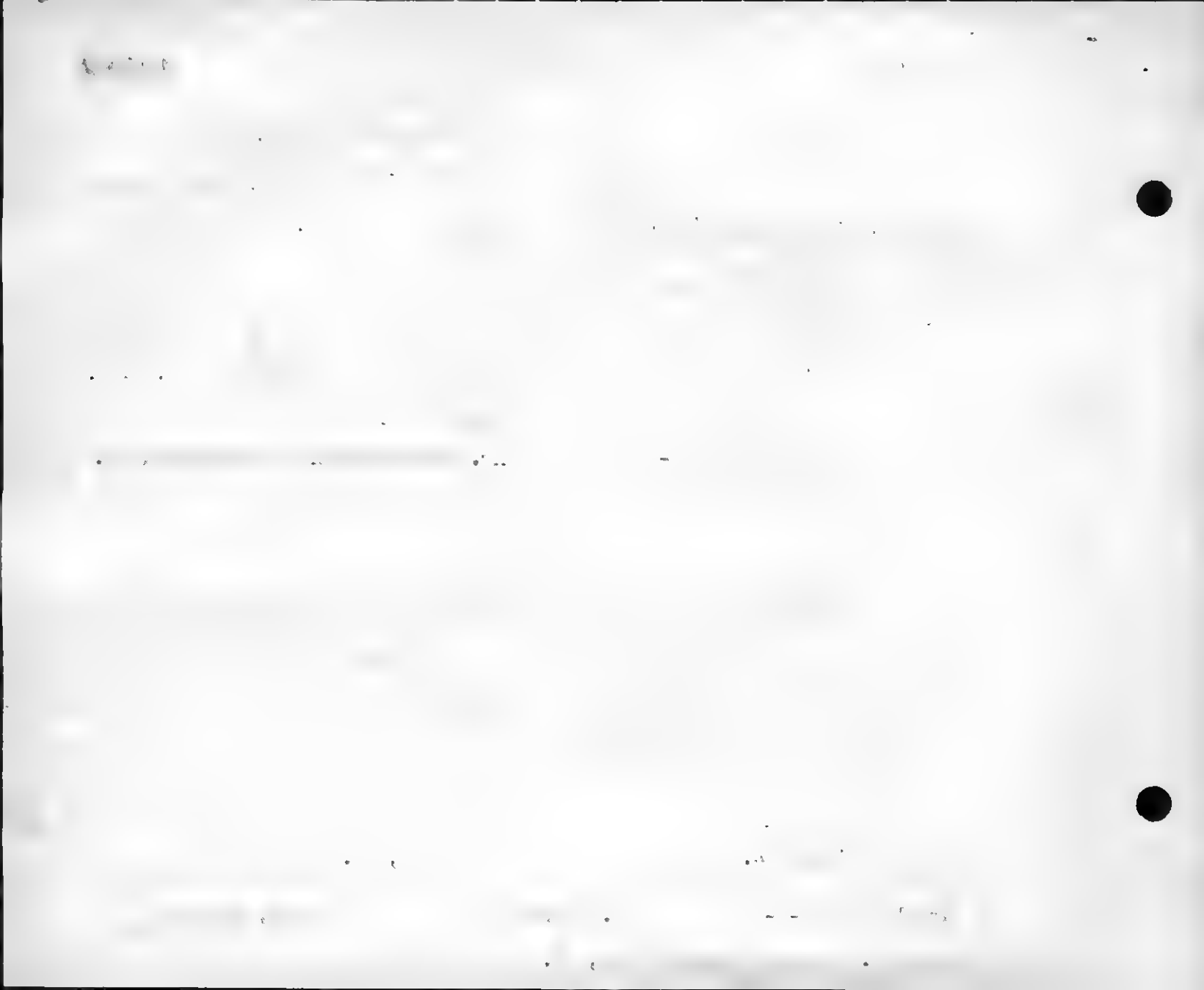
CERTIFICATE OF DEATH

14382

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring (Univ. Nursing Home)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>901 Apollo Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth Louise Hutton</b>		4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>1/16/1875</b>
9. AGE (in years last birthday) <b>91</b>		10. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William B. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Elizah Hopkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mr. Josiah Hutton</b>		Address <b>Brookeville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1947</b> to <b>Oct 1</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/30</b> , 19 <b>66</b> , and that death occurred at <b>9:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Richard A. Yates</b>		22b. DATE SIGNED <b>10-1-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard A. Yates</b>		22d. ADDRESS <b>Olney, Md.</b>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-3-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>	23d. LOCATION (City or Town) (County) (State) <b>Olney, Maryland</b>
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR <b>1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Laytonsville, Md.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

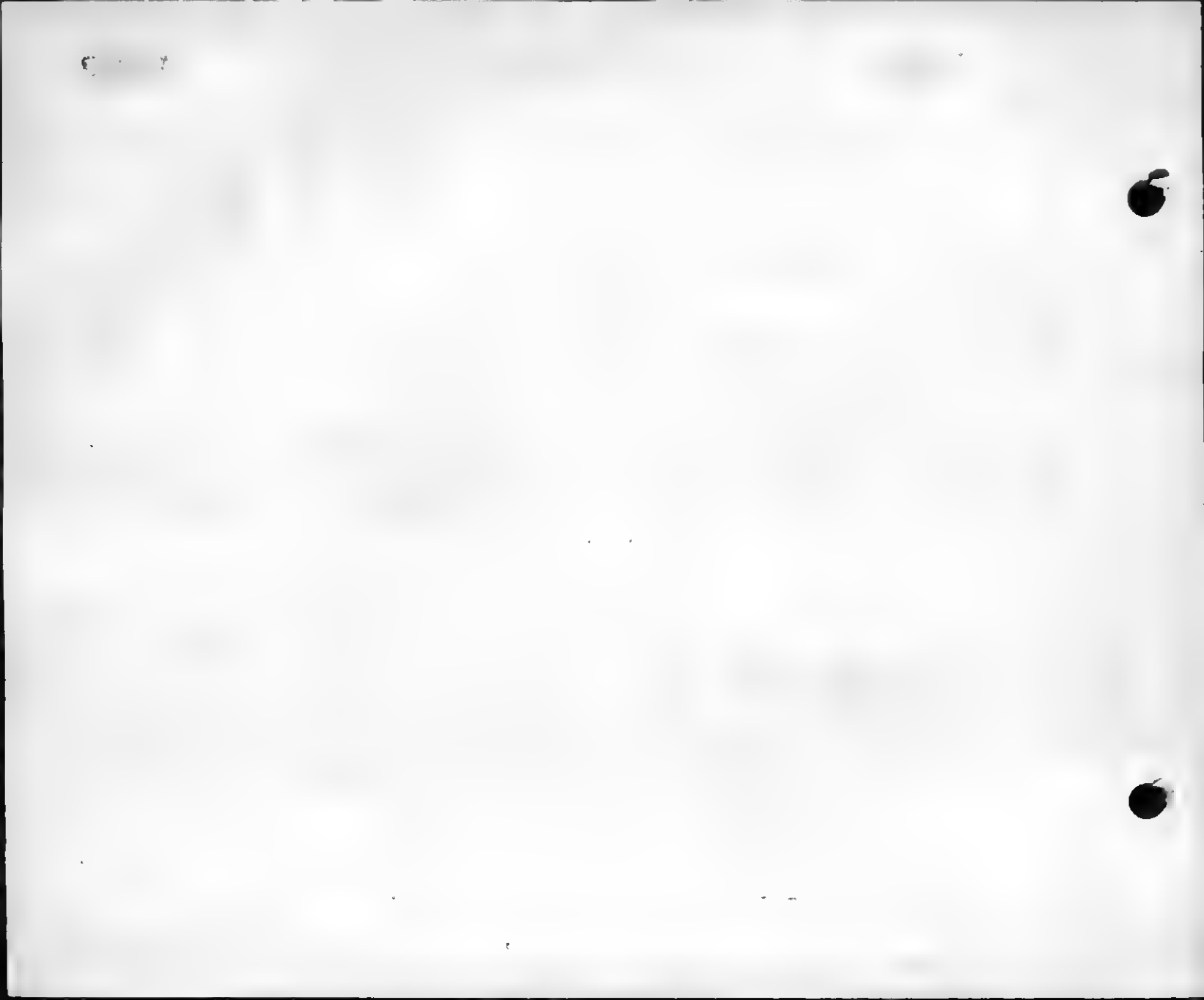
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
14383		Item #7 Filled		CERTIFICATE OF DEATH		14383							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>✓</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradford Rest Home</u> 15-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bradford Rest Home</u>				d. STREET ADDRESS <u>RI, Silver Spring</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Henry</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>3</u> Year <u>1966</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-25-98</u> <u>68</u> yrs.		9. AGE (In years last birthday) Months <u>6</u> Days <u>8</u> Hours <u>15</u> Min.		IF UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Carroll, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-30-3639</u>				17. INFORMANT <u>Record Bradford Nursing Home</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> ++ DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Atherosclerotic C.U. Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>3-25</u> , 19 <u>66</u> to <u>10-3</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10-3</u> , 19 <u>66</u> and that death occurred at <u>9A</u> M. from the causes and on the date stated above.													
22a. SIGNATURE <u>Clive E. Jackson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>10-3-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Clive E. Jackson</u>				22d. ADDRESS <u>202 Martin Ln. Rockville, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10-8-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Church.</u>		23d. LOCATION (City, town or county) (State) <u>Damascus, Md.</u>					
24. FUNERAL DIRECTOR <u>Robert L. Sworden</u>				ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14384

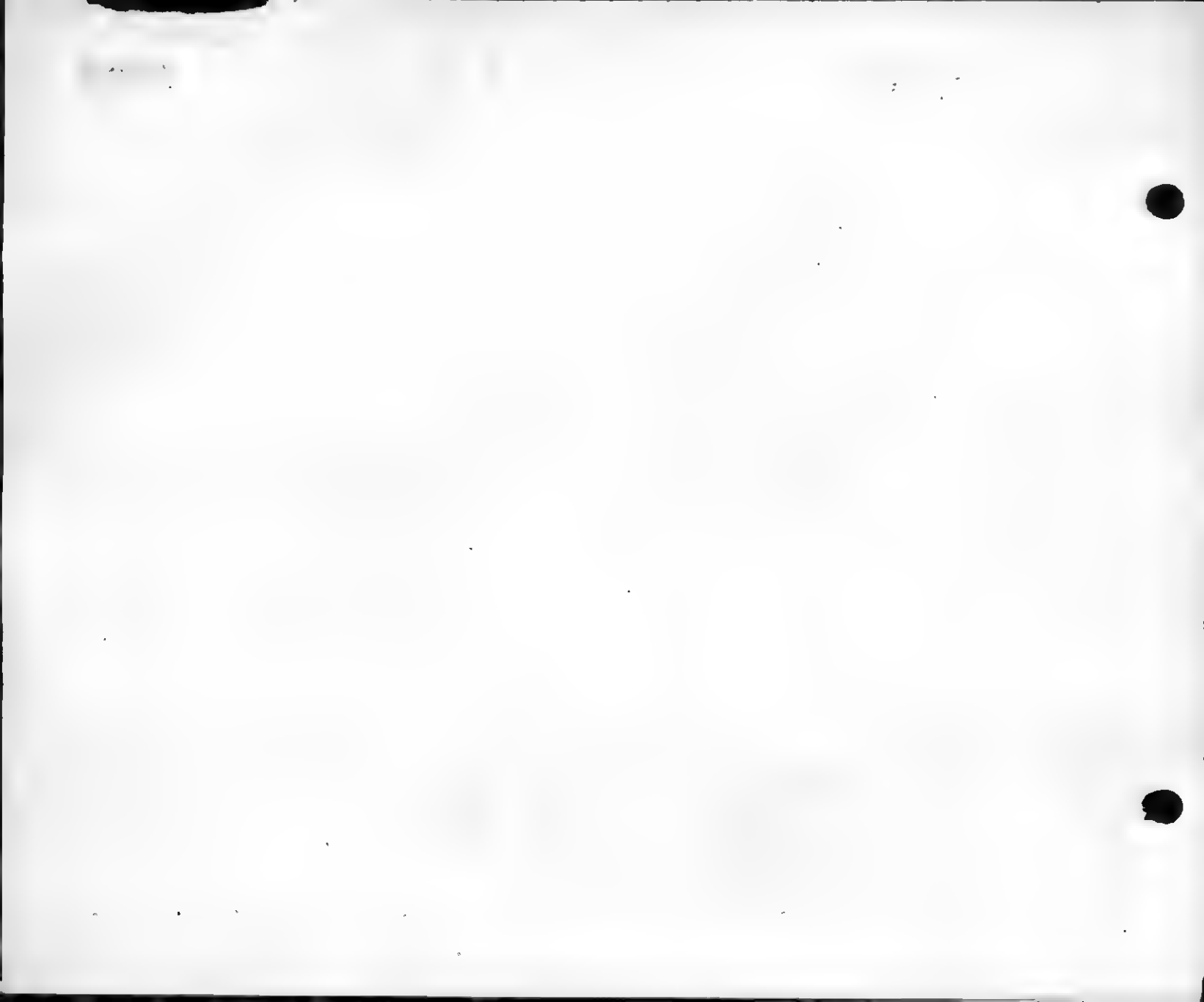
## CERTIFICATE OF DEATH

14384

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laytonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DeBachan</u>		e. STREET ADDRESS <u>Wil</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Henry</u> Middle <u>Jackson</u> Last		4. DATE OF DEATH <u>Oct 6</u> 19 <u>66</u> Month <u>Oct</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col-</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. AGE (In years last birthday) <u>53</u> Yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Team Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Shuman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Sister Mildred Butler</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus with</u> <u>150X</u> DUE TO <u>generalized metastasis and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>marked cachexia</u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 1966</u> to <u>Oct 5</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Oct 5</u> , 19 <u>66</u> and that death occurred at <u>  </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>V.C. Lefman, MD</u> M.D.		22b. DATE SIGNED <u>Oct 6, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Vicente E. de Guzman MD</u>		22d. ADDRESS <u>1234 19th NW. Wash D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10-10-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brooker Grove Church</u>	23d. LOCATION (City or Town) (County) (State) <u>Laytonsville, Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Surdness</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 11 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14385

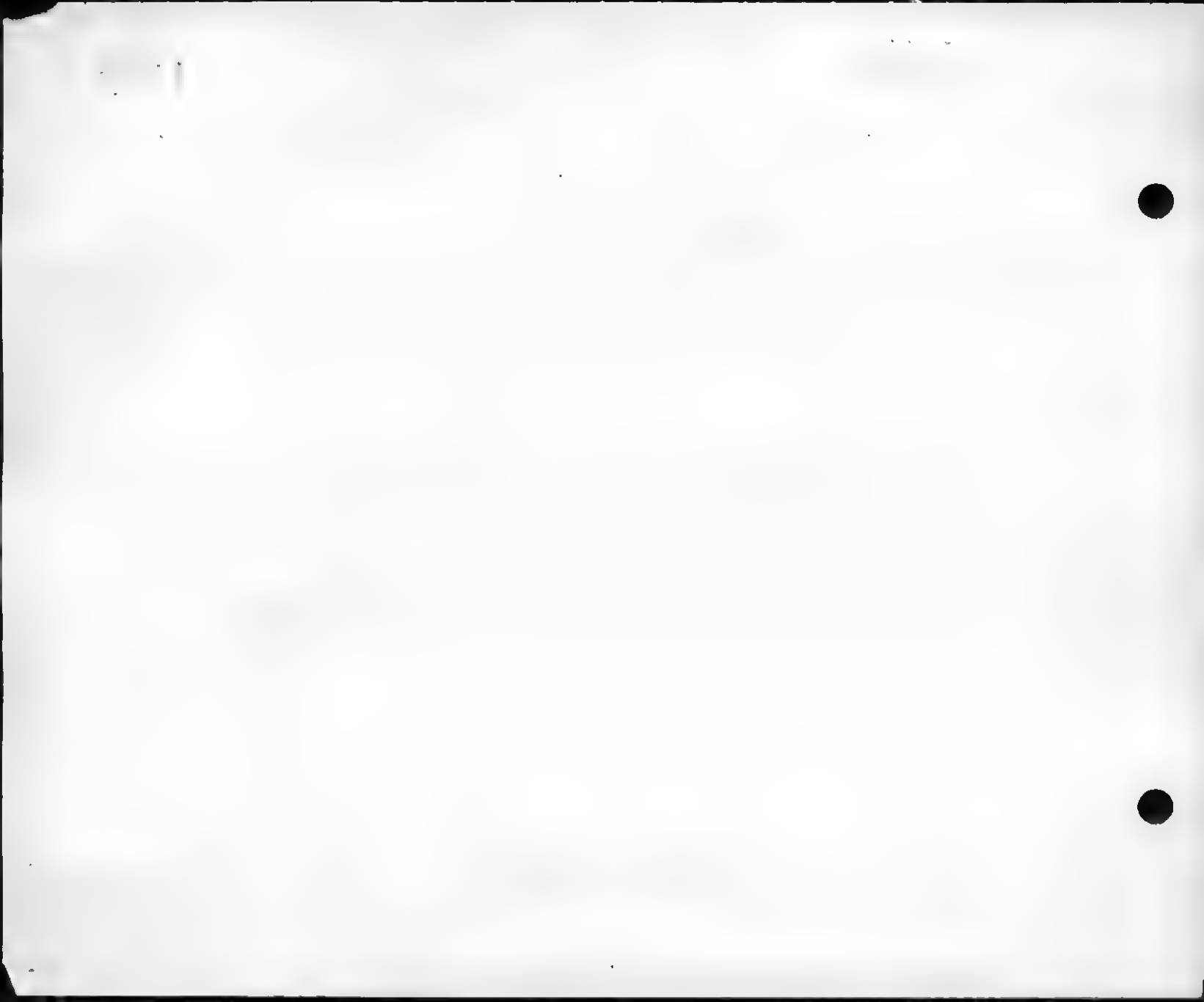
CERTIFICATE OF DEATH

14385

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
c. LENGTH OF STAY IN <u>5 weeks</u>		d. STREET ADDRESS <u>8299 Sudlersville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mabel Elizabeth Jackson</u>		4. DATE OF DEATH Month Day Year <u>Oct. 16 1966</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/13/01</u>
9. AGE (in years last birthday) <u>65 yrs</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Anna Lawson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>W. S. &amp; H Hospital Records</u>		Address <u>Takoma Park Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Carcinomatous</u> DUE TO (b) <u>probably Hepatic Coma 2°</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Congestive Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Congestive Failure</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/11</u> , 19 <u>66</u> , to <u>10/15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> , 19 <u>66</u> , and that death occurred at <u>8:45 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Russell C. Bufalino</u>		22b. DATE SIGNED <u>Oct 15, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell C. Bufalino, MD</u>		22d. ADDRESS <u>1429 University Blvd. W. S. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct 18, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Willam McCallandran Foun. Co. Pa.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Arthur Walker</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 18 1966</u>	

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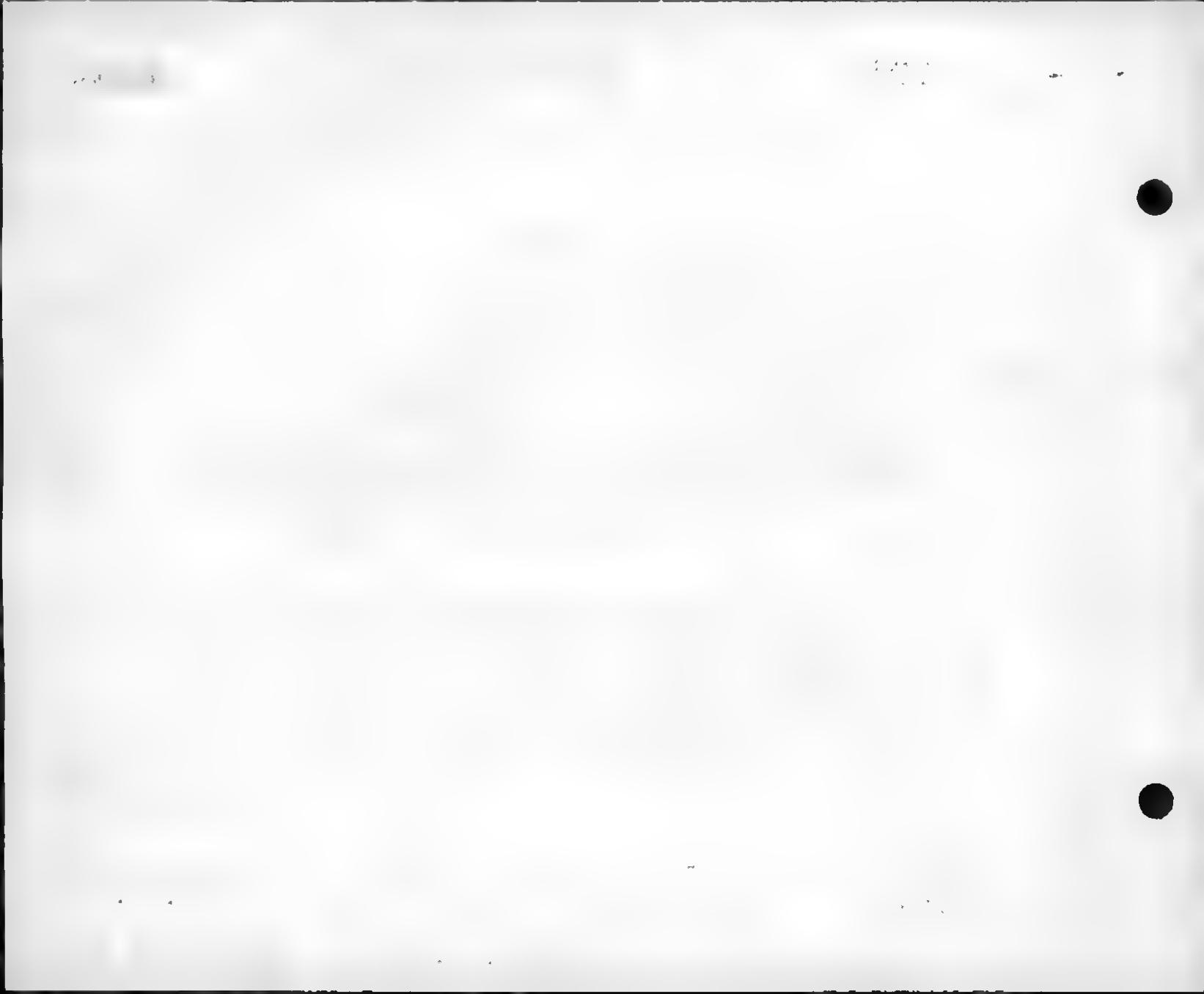
14386

CERTIFICATE OF DEATH

14386

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENBELT</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp. of Silver Spring</u>		d. STREET ADDRESS <u>850501 Glendale Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Matthew Joseph John</u>		4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1966</u>
9. AGE (In years lost birth day) yrs <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Ross John</u>		14. MOTHER'S MAIDEN NAME <u>Marjorie Ann Lipps</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joseph Ross John</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrauterine hemorrhage</u> <u>1600</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>in a newborn infant</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 10</u> , 19 <u>66</u> , to <u>Oct. 12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct. 12</u> , 19 <u>66</u> , and that death occurred at <u>7:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Frank Neuberger</u>		22b. DATE SIGNED <u>Oct. 12, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK Neuberger</u>		22d. ADDRESS <u>1110 Spring Street, Silver Spring</u>	
23a. BURIAL, CREMATION, or other disposition (Specify)	23b. DATE THEREOF <u>10/17/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

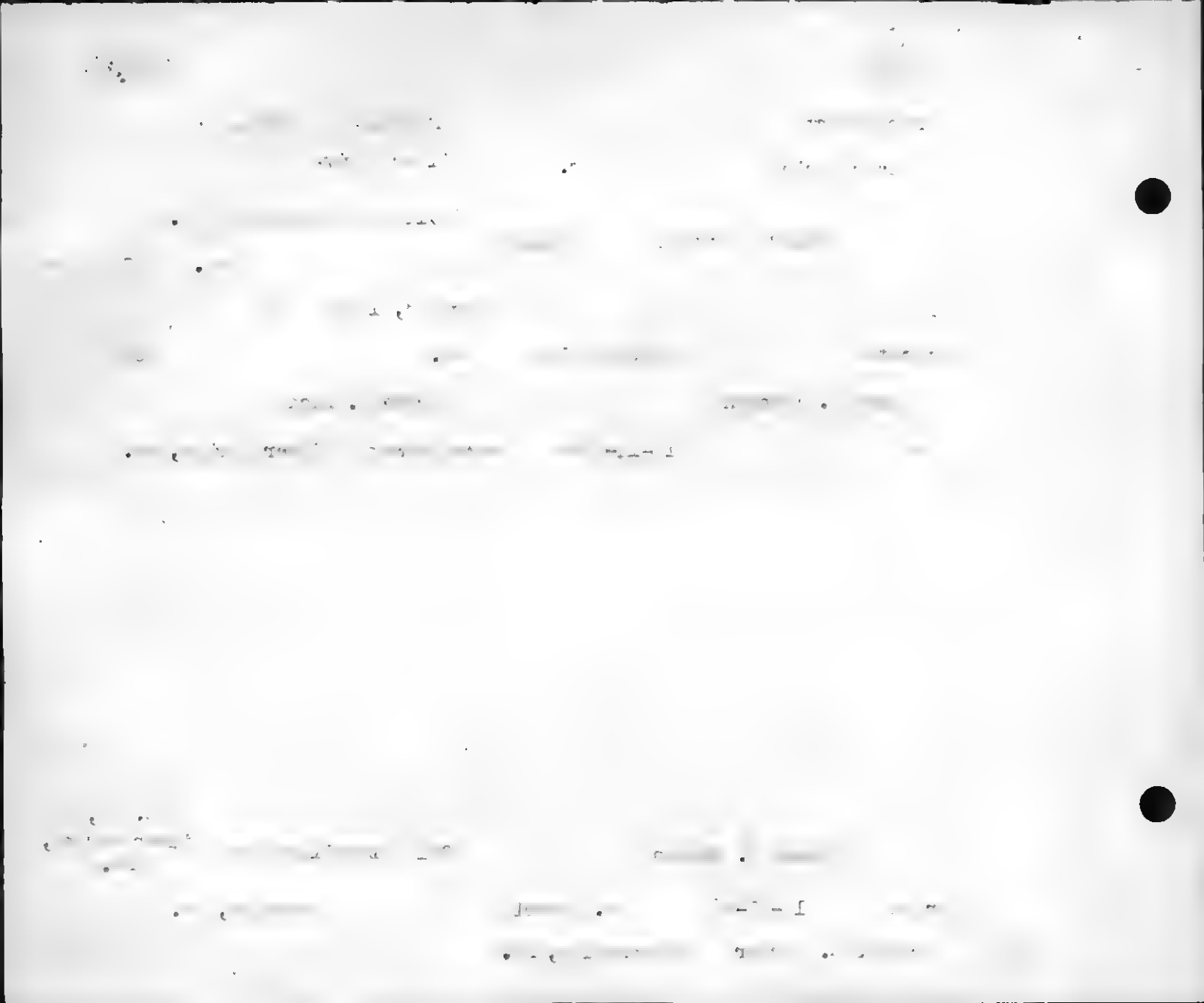
14387

CERTIFICATE OF DEATH

14387

Item #1d Film #4382-10/20/66

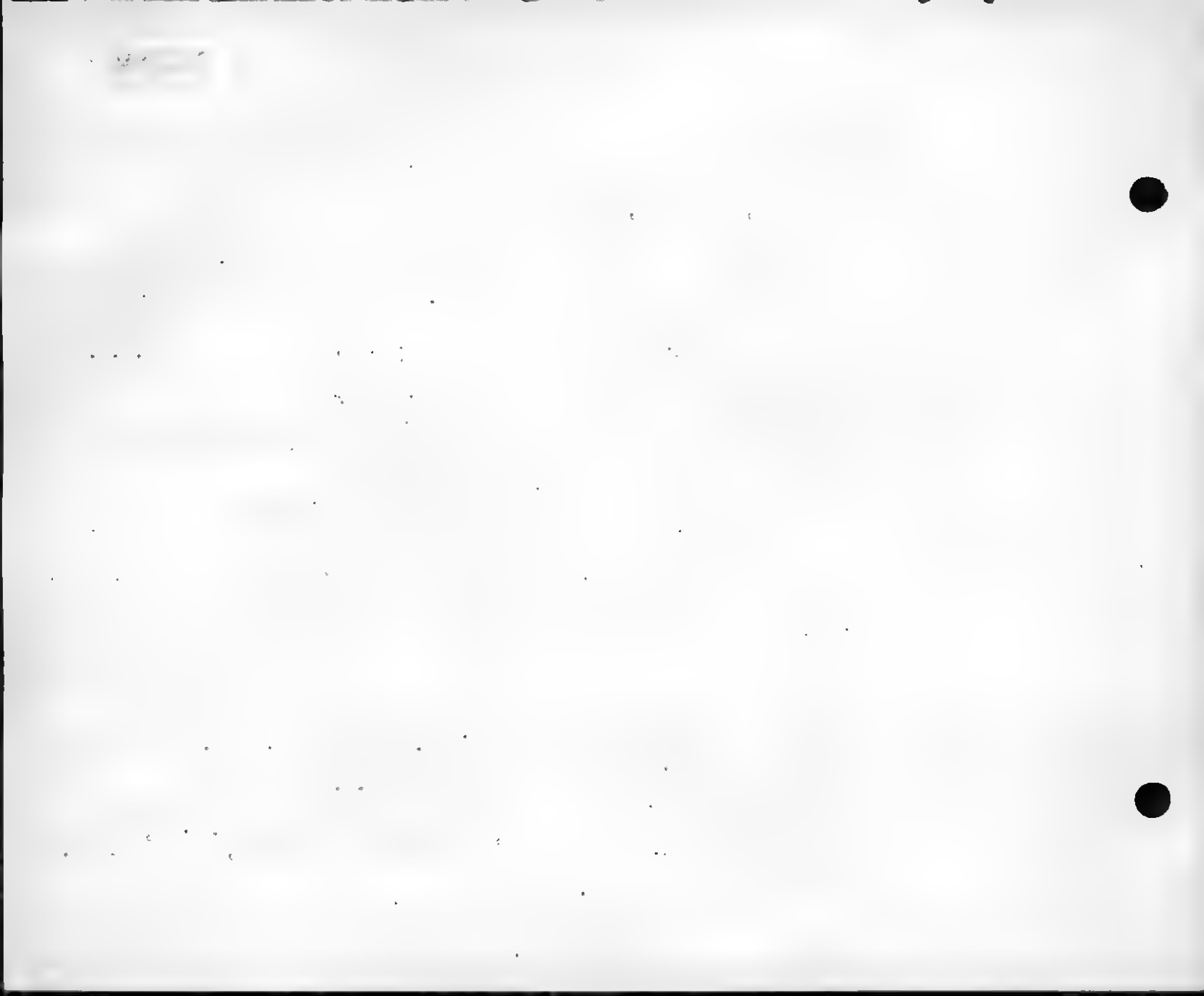
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>5 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>11912 New Hampshire Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edgar Fenton Johnson</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>13</b> Year <b>1966</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 8, 1894</b>		9. AGE (in years last birthday) <b>72 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James E. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Martha E. Lucas</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>212-14-5308</b>		17. INFORMANT <b>Helen Doheny</b>		Address <b>Silver Spring, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>Generalized atherosclerotic cardiovascular disease</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24-48 hrs.</b> <b>2-3 yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Generalized atherosclerotic, prostatic hypertrophy</b>		20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year <b>1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7:00 AM</b> , 1966, to <b>1:30 PM</b> , 1966, that (II) (we) last saw the deceased alive on <b>13 Oct</b> , 1966, and that death occurred at <b>11 A</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>Ernest E. Harmon</b>		22b. DATE SIGNED <b>Oct. 13, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Ernest E. Harmon</b>		22d. ADDRESS <b>9301 Colesville Road</b>		22e. CITY OR TOWN <b>Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-17-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>		23d. LOCATION (City, town or county) (State) <b>Sunshine, Md.</b>		24. FUNERAL DIRECTOR <b>Francis H. Parber</b>		24b. ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 18 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>OCT 18 1966</b>		25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25e. DATE <b>OCT 18 1966</b>		25f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25g. DATE <b>OCT 18 1966</b>		25h. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14388 CERTIFICATE OF DEATH 14388									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					c. LENGTH OF STAY IN 1b <b>24 days</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chambersburg</b>				
					d. STREET ADDRESS <b>120 Ramsey Avenue</b>				
3. NAME OF DECEASED (Type or print) First <b>Ira</b> Middle <b>Samuel</b> Last <b>Johnson</b>					4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 December 1928</b>		9. AGE (In years last birthday) <b>37 yrs.</b> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>9</b> Days <b>25</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence Johnson</b>					14. MOTHER'S MAIDEN NAME <b>Helen Wiser</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1950-1952</b>					16. SOCIAL SECURITY NO. <b>162-22-6305</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Esophageal Hemorrhage</b> <b>1967</b> DUE TO <b>Esophagus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic malignant Melanoma invading/</b> <b>2 Months</b> DUE TO (c) <b>Primary Malignant Melanoma of skin in the Thorax</b> <b>3 Years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thrombocytopenia</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <b>a.m.</b> <b>19</b> Month, Day, Year			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>28 Sept.</b> , <b>1966</b> , to <b>22 Oct.</b> , <b>1966</b> , that <del>XX</del> (we) last saw the deceased alive on <b>22 Oct.</b> , <b>1966</b> , and that death occurred at <b>7:55 P.M.</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Leroy Fass</b>					22b. DATE SIGNED <b>P.M. 10/23/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Leroy Fass, MD.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <b>10/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Chambersburg Pa.</b>		
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey F.H. 7557 Wisc. Ave Bethesda, Md.</b>					25a. REC'D BY REGISTRAR <b>OCT 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





Closed with medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

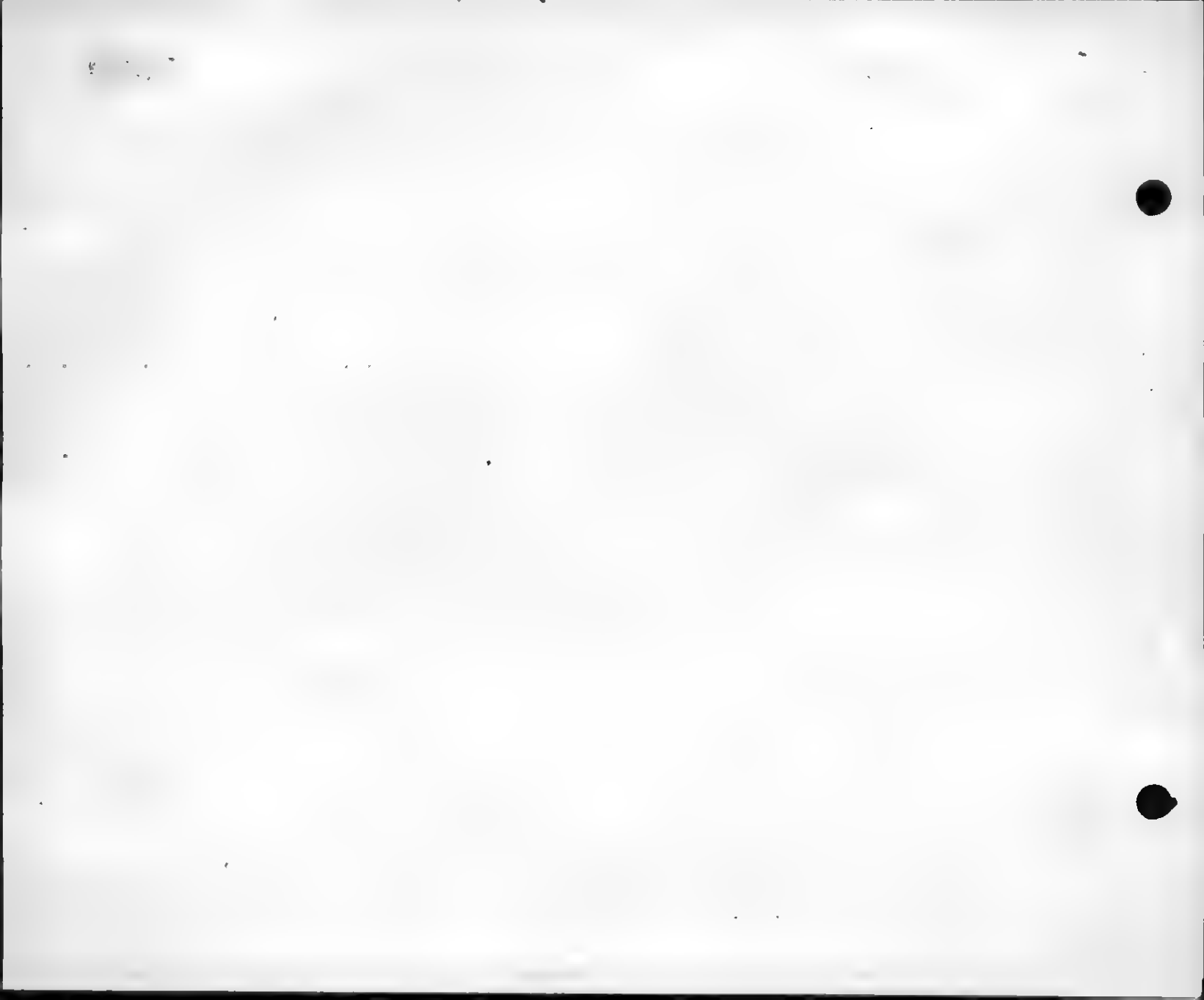
1 (M)

14389

CERTIFICATE OF DEATH

14389

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spring</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>12829 Spring Tree</u>	
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>Mae</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20 10/20/1900</u>
9. AGE (In years last birthday) <u>65 yrs</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>23</u> Hours <u>15</u> Min. <u>45</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A. Rochester, Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Morey (Unknown)</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Son</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>1 week</u> <u>15 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>April</u> , 19 <u>66</u> , to <u>Oct 23</u> , 19 <u>66</u> , that (we) last saw the deceased alive on <u>Oct 20</u> , 19 <u>66</u> , and that death occurred at <u>11:02 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>George Skenton</u>		22b. DATE SIGNED <u>10/23/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE SKENTON</u>		22d. ADDRESS <u>10829 Georgia Avenue, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-26-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert O. Humphrey</u>		25a. REC'D BY REGISTRAR <u>Oct 24, 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>		25c. REGISTRAR'S NAME <u>John Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

14390

14390

1 PLACE OF DEATH a COUNTY <u>Mont.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Mont.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY (in days) <u>13</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7045 Wilson Lane</u>		e STREET ADDRESS <u>7045 Wilson Lane</u>	
3 NAME OF DECEASED (Type or print) <u>Anna Margaret Kart</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/30/99</u>
9 AGE (In years last birthday) <u>67</u> yrs		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homestic</u>		12 KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
13 FATHER'S NAME <u>Unknown</u>		14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>Hospital records</u>	
17 INFORMANT <u>Hospital records</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction, recent and remote</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Years.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball, 7936 Old Georgetown Road, Bethesda, Maryland</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF	
<u>Burial</u>		<u>11/2/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d LOCATION (City or Town) (County) (State) <u>Prince George Co Md.</u>	
24 FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25 REGISTRATION <u>Rockville, Maryland</u>	
26 RECD BY REGISTRAR <u>NOV 2 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and on any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

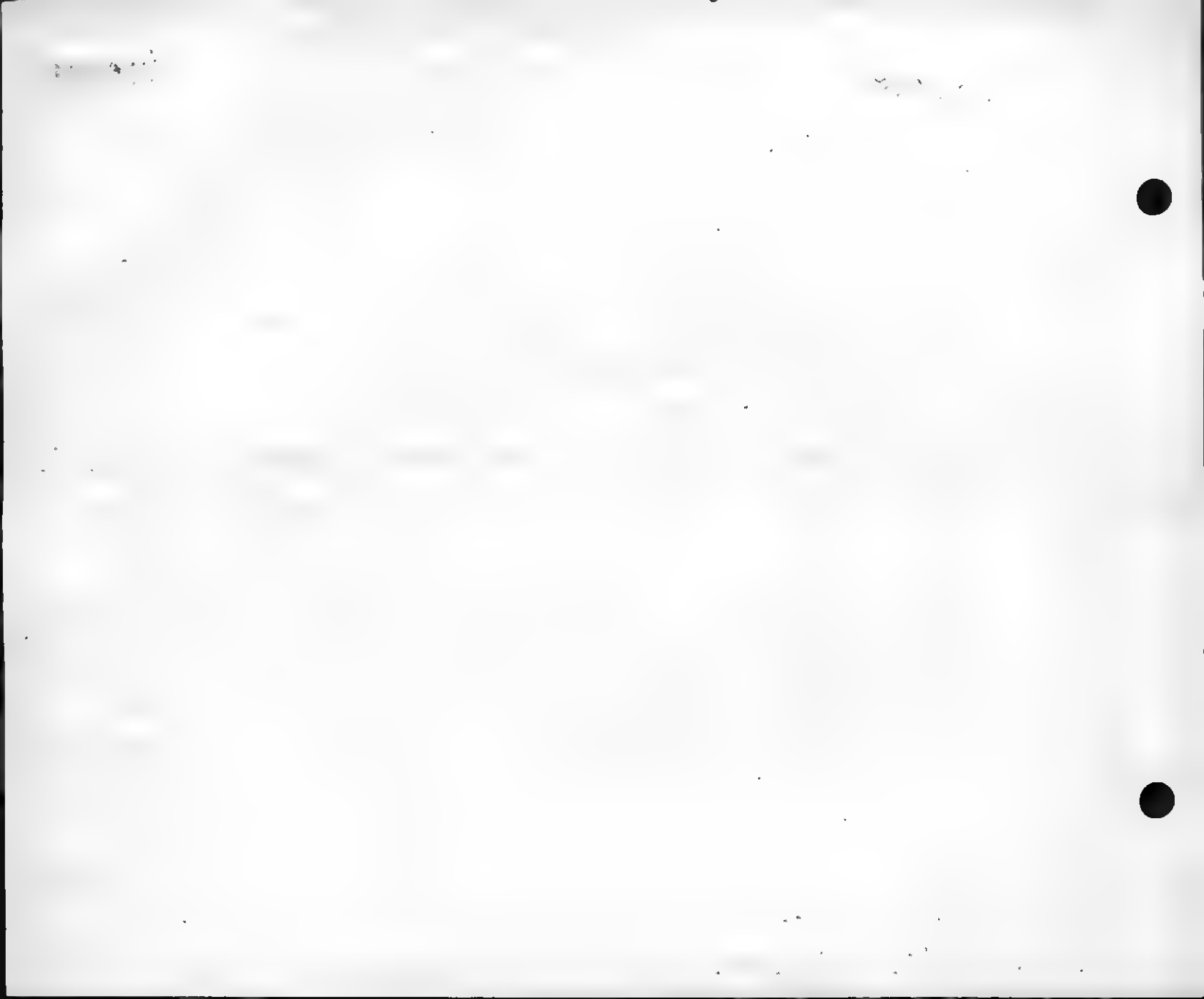
CERTIFICATE OF DEATH

14391

14391

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>Three 40 min</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>				d. STREET ADDRESS <u>9506 Baltimore Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Eckles</u> Last <u>Kay</u>				4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-82</u>	9. AGE (In years last birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Kay</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>577-10-7882A</u>		17. INFORMANT <u>Evelyn Sokles</u> Address <u>10016 Dallas Ave. Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Gastric Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of Stomach</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> , 19 <u>66</u> , to <u>Oct 15</u> , 19 <u>66</u> , that (I) (we) lost the deceased alive on <u>Oct 15</u> , 19 <u>66</u> , and that death occurred at <u>10:45 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>W.B. Wardrop, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 16, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.B. WARDROP, M.D.</u>				22d. ADDRESS <u>508 Pershing Drive Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 18, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Barner &amp; Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				DATE <u>OCT 19 1966</u>		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

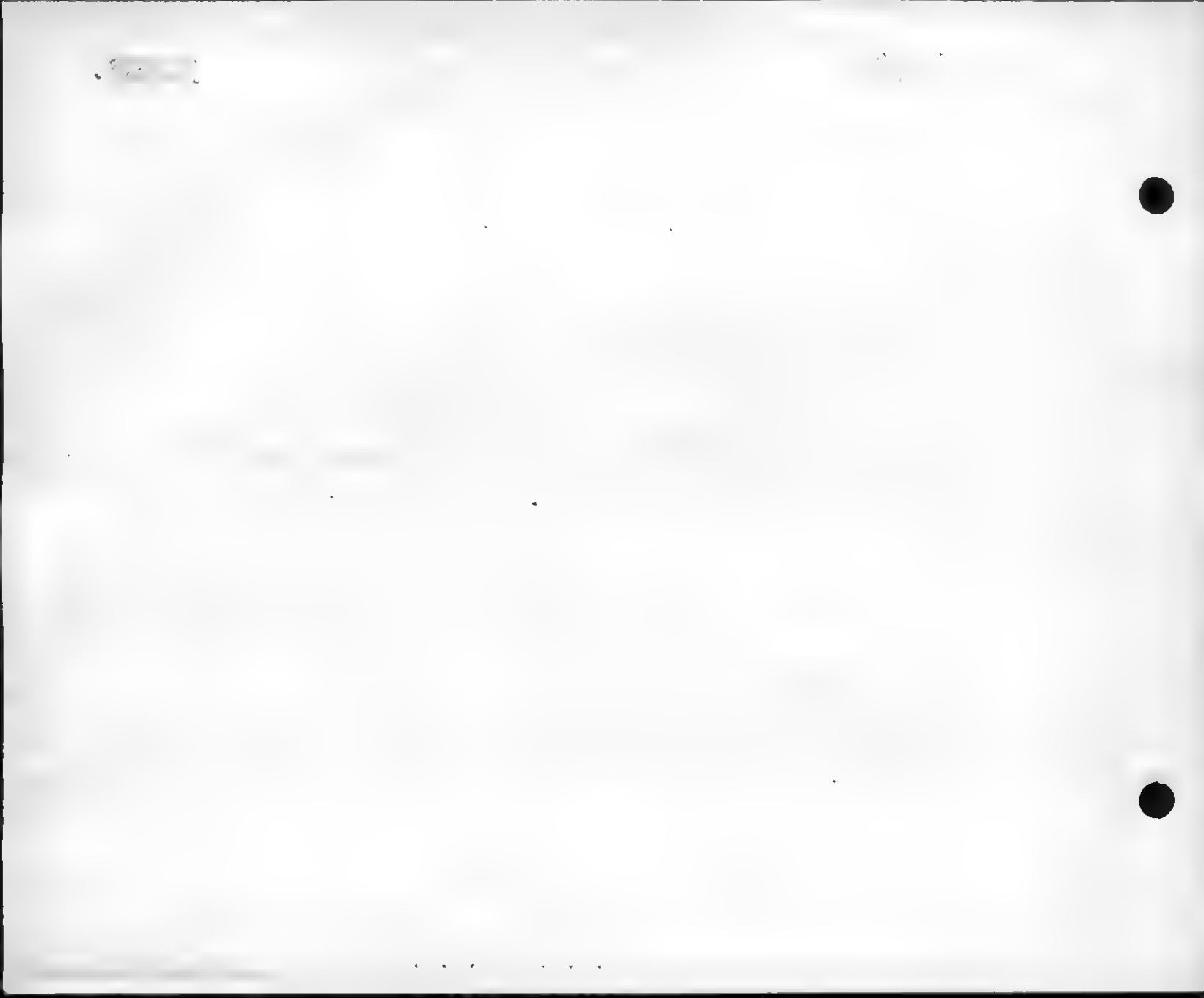
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14392

CERTIFICATE OF DEATH

14392

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>KENSINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>2710 FENNINGS ROAD</u>	
3 NAME OF DECEASED (Type or print) <u>ELIZABETH</u>		4 DATE OF DEATH <u>OCTOBER 18 1966</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/90</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>PAUL LEAN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH DICK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>11605 LOCKWOOD DR 53</u>	
17 INFORMANT <u>Paul J. Kern</u>		Address <u>11605 Lockwood Dr 53</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>IRREVERSABLE SHOCK</u> DUE TO (b) <u>SADDLE EMBOLUS AORTIC BIFURCATION</u> DUE TO (c) <u>MYOCARDIAL INFARCTION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>22 DAYS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1966</u> to <u>18 OCT 1966</u> that (I) <u>(last)</u> saw the deceased alive on <u>18 OCT 1966</u> and that death occurred at <u>7:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Walter Edgorth</u>		22b. DATE SIGNED <u>10-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER EDGORTH MD</u>		22d. ADDRESS <u>2390 Glenmont Circle, Wheaton, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-20-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elesavetgrad Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, DC</u>
24. FUNERAL DIRECTOR <u>Bernard Danzansky &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>3501-14th St. N.W. Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14393

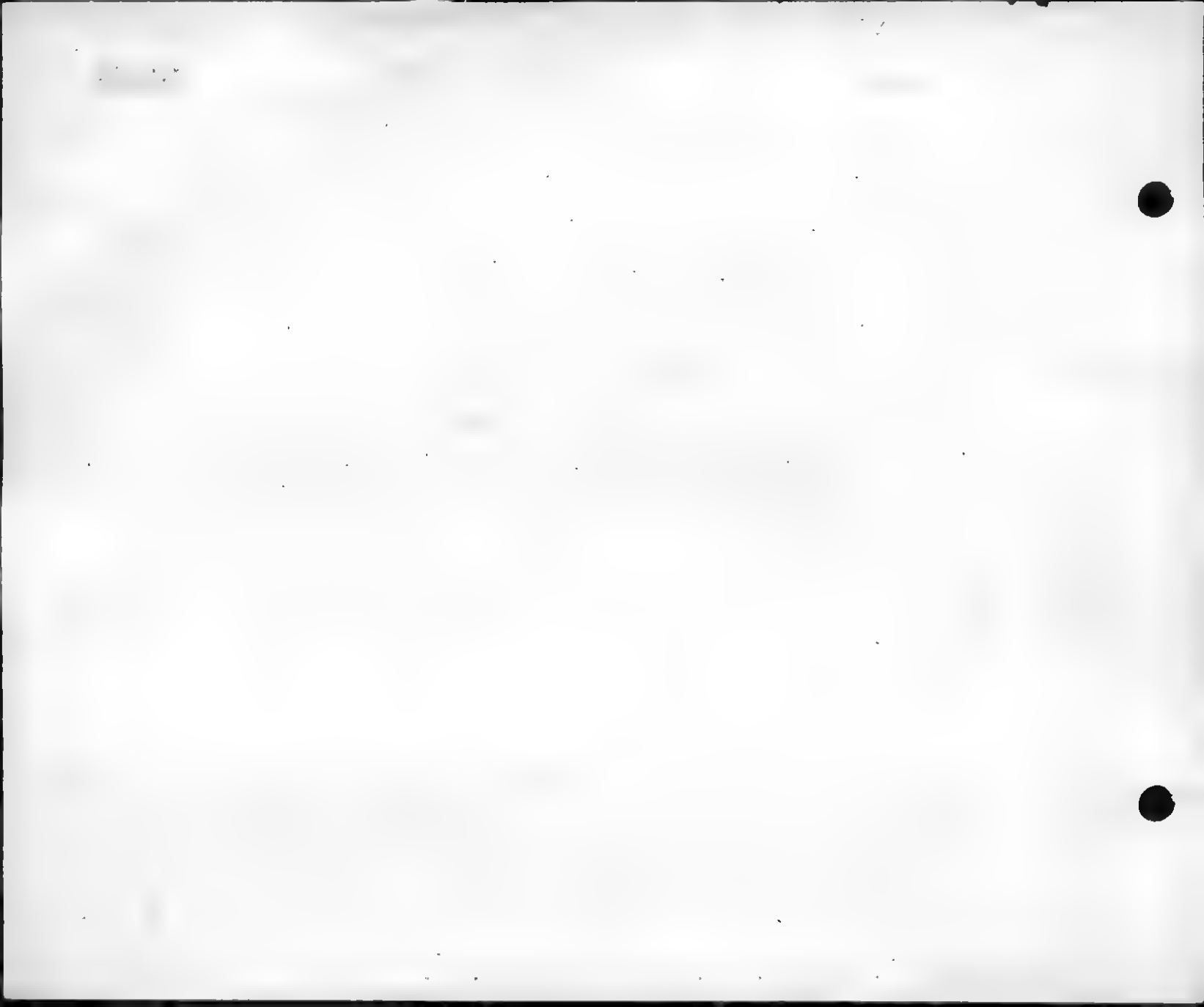
## CERTIFICATE OF DEATH

14393

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		d. STREET ADDRESS <u>408 Windsor St.</u>	
3 NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Garden</u> Last <u>Kindness</u>		4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-1-98</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Gov't</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Kindness</u>		14. MOTHER'S MAIDEN NAME <u>Georgeanna Robb</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>577-07-4375</u>	
17 INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary occlusion</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia, secondary anemia, Emphysema</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>30 October</u> , 19 <u>66</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>30 October</u> 19 <u>66</u> , and that death occurred at <u>3:10 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Russell B. Arnold</u>		22b. DATE SIGNED <u>10-3-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>		22d. ADDRESS <u>1106 Spring Street Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 5, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Clark &amp; Wisor</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Clark &amp; Wisor</u> <u>8434 Georgia Ave. Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>OCT 6 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

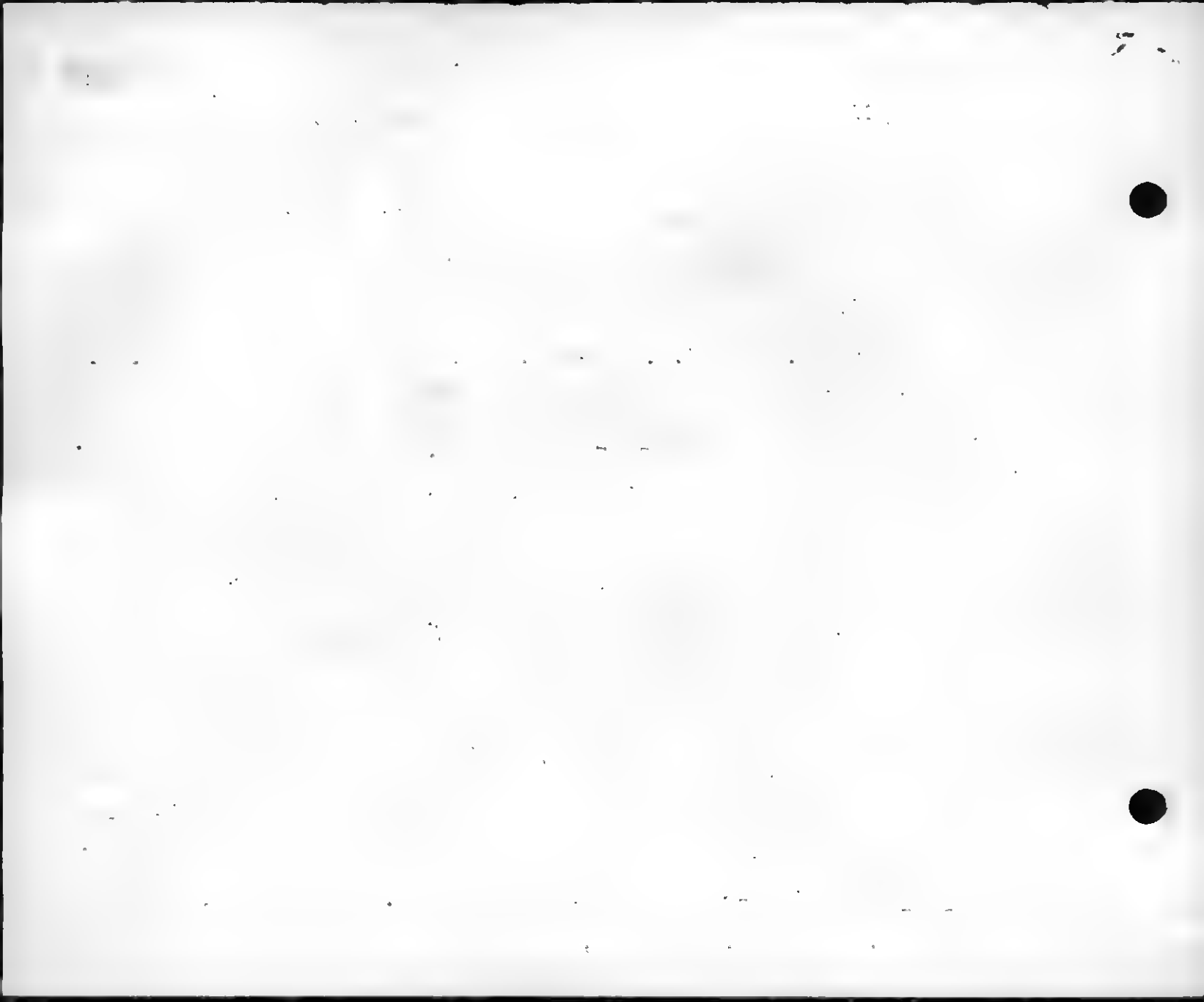
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14394 1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11406 Viers Mill Road</b>						14394 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>508 Fletcher Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>WALTER - L - KIRK</b>			4. DATE OF DEATH <b>OCT. 16 1966</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>12/5/99</b>			9. AGE (In years last birthday) <b>66</b> yrs.			10. BIRTH PLACE (County & State, or foreign country) <b>Illinois</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Controlman-Eng. Room</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt-Ret.</b>			11. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			12. FATHER'S NAME <b>Jay Bird Kirk</b>		
13. FATHER'S NAME <b>Jay Bird Kirk</b>			14. MOTHER'S MAIDEN NAME <b>Sadie Tidd</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>WW 1</b>		
17. INFORMANT <b>Wife</b>			18. ADDRESS <b>Same as Item 2.</b>			19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			20. SOCIAL SECURITY NO. <b>WW 1</b>		
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION MASSIVE</b> DUE TO <b>CORONARY ARTERY DISEASE ANGINA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSION ARTERIOSCLEROSIS</b> DUE TO <b>HYPERTENSION ARTERIOSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>HEPATIC CIRRHOSIS LIVER DISEASE</b>			22. INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b>			23. YEARS <b>4</b>			24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			25b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			26. TIME OF INJURY Month, Day, Year <b>19</b>			27. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			29. (City or town) (County) (State)			30. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> , 1963, to <b>10/16</b> , 1966, that (I) (we) last saw the deceased alive on <b>10/16</b> , 1966, and that death occurred at <b>10/16</b> , 1966, from the causes and on the date stated above.			31. SIGNATURE <b>Charles Farwell</b>		
32. PHYSICIAN'S NAME (Type) <b>CHARLES FARWELL</b>			33. ADDRESS <b>11406 Viers Mill Rd. Wheaton, Maryland</b>			34. DATE SIGNED <b>10-16-66</b>			35. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
36. BURIAL, CREMATION, REMOVAL (Specify)			37. DATE THEREOF <b>10-19-66</b>			38. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem.</b>			39. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>		
40. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>			41. ADDRESS <b>Bethesda, Maryland</b>			42. REC'D BY REGISTRAR <b>OCT 20 1966</b>			43. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

14395

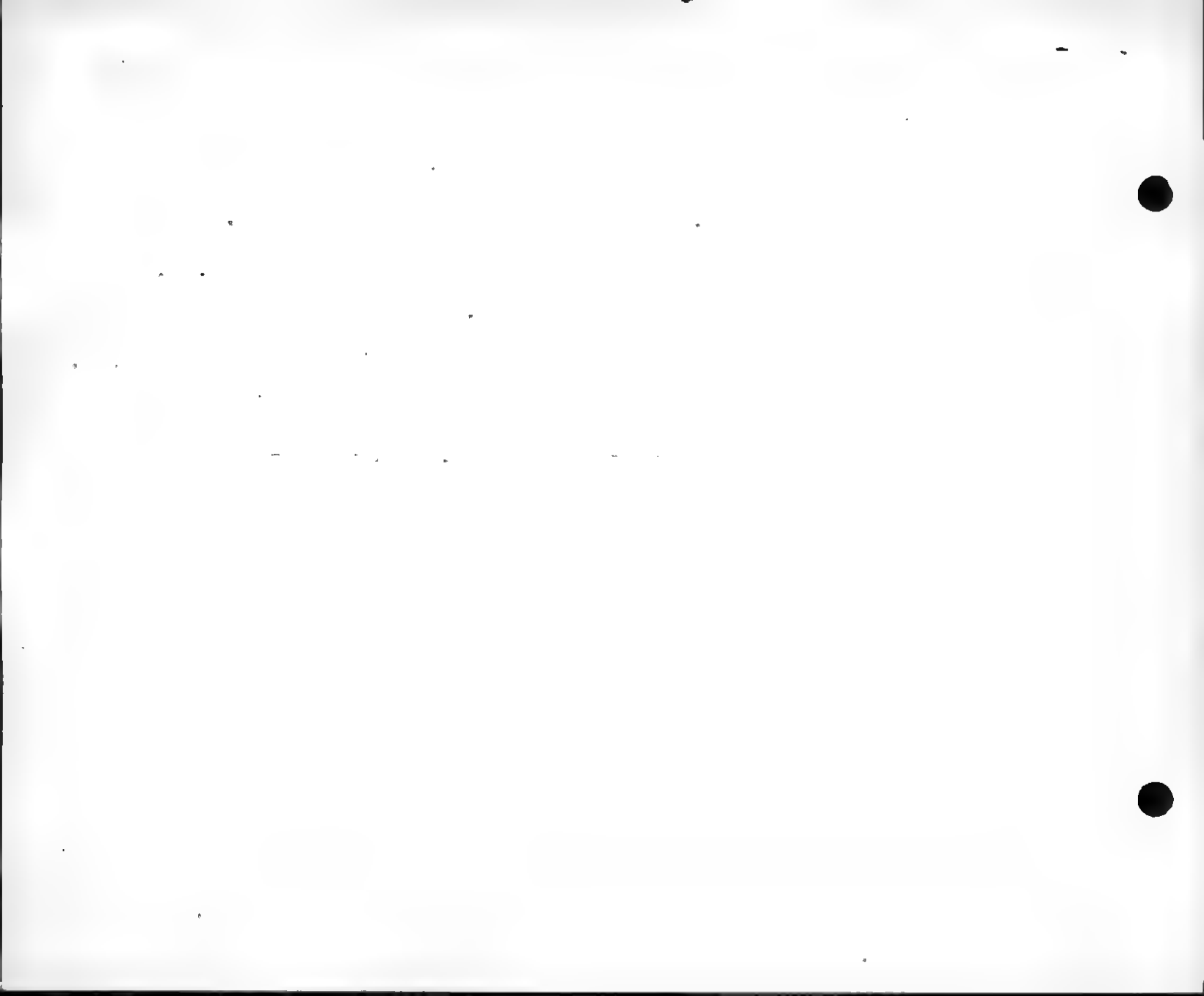
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14395

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c LENGTH OF STAY in 1b <b>30 Years</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4600 Highland Ave.</b>		d STREET ADDRESS <b>4600 Highland Ave.</b>	
3 NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>JAMES</b> Last <b>KLAK</b>		4 DATE OF DEATH Month <b>Oct.</b> Day <b>1</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec. 17, 1900</b>
9 AGE (In years last birthday) <b>65</b> yrs		10 IF UNDER 1 YEAR Months <b>9</b> Days <b>14</b> Hours <b></b> Min <b></b>	11 IF UNDER 24 HRS Hours <b></b> Min <b></b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Legal</b>	
11 BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13 FATHER'S NAME <b>Ignace Klak</b>		14 MOTHER'S MAIDEN NAME <b>Frances Tomkowiak</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <b>Yes</b>		16 SOCIAL SECURITY NO <b>577-48-3967</b>	
17 INFORMANT <b>Ruth H. Klak - Wife - Same Item #2</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per Part I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer of Pancreas</b> <b>157X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>with liver metastasis</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>Oct. 1, 1966</b>	
ACTUAL SIGNATURE <b>Belden R. Peap</b> M.D. EXAMINER'S NAME (Type) <b>BELDEN R. PEAP, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>10-5-66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem.</b>	23d LOCATION (City or town) (County) (State) <b>Arlington, Virginia</b>
24 FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a REC'D BY REGISTRAR DATE <b>OCT 7 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #23d Film #382 11/27/66

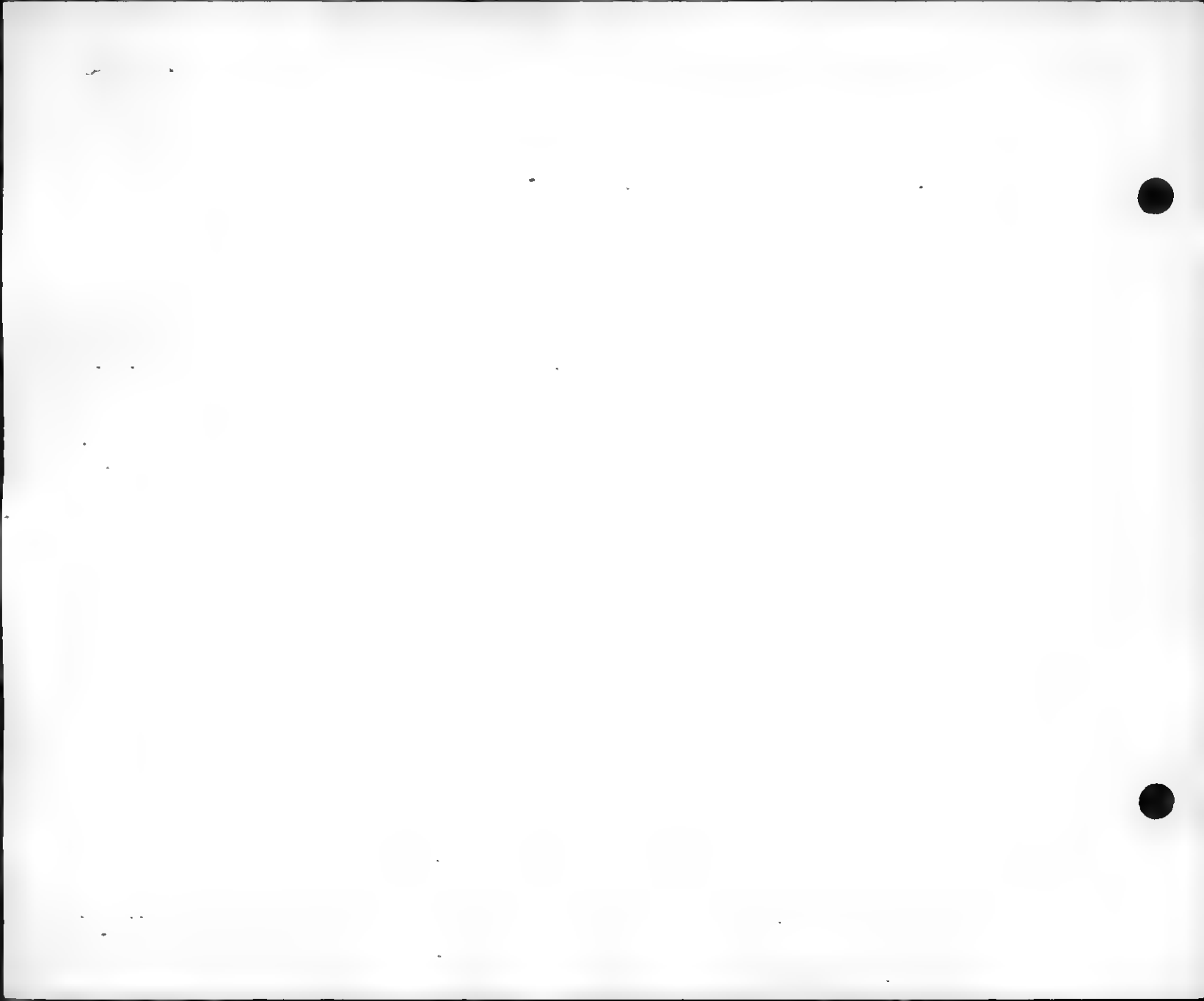
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14396

14396

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>				c LENGTH OF STAY IN b <u>16 yrs. D.D.M.S.</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Centerhill 11907 Centerhill Rd.</u>				d STREET ADDRESS <u>Centerhill 11907 Centerhill Rd.</u>			
3 NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>MELVIN</u> Last <u>KLINE</u>				4 DATE OF DEATH Month <u>OCT</u> Day <u>17</u> Year <u>1966</u>			
5 SEX <u>M.</u>		6 COLOR OR RACE <u>W.</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>8/11/1903</u>	
9 AGE (In years last birthday) <u>63</u> Yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Classified Analyst</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Veterans Adm.</u>		11 BIRTHPLACE (State or foreign country) <u>Altoona, Pennsylvania</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13 FATHER'S NAME <u>John B. Kline</u>			
14 MOTHER'S MAIDEN NAME <u>Snow</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. etc.) <u>No</u>			
16 SOCIAL SECURITY NO <u>216-44-3083</u>				17 INFORMANT <u>Dolores C. Kline</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f (City or town) _____ (County) _____ (State) _____	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
7936 Old Georgetown Rd. Bethesda, Maryland				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/18/66			
Address (Street city, town, or county)				22. DATE SIGNED			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Oct. 21, 1966</u>		23c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d LOCATION (City or town) _____ (County) _____ (State) _____ <u>Prince Georges Co., Md.</u>	
24 FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>				25a REC'D BY REGISTRAR <u>Charles Judge</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>				DATE <u>OCT 24 1966</u>			

13 p.

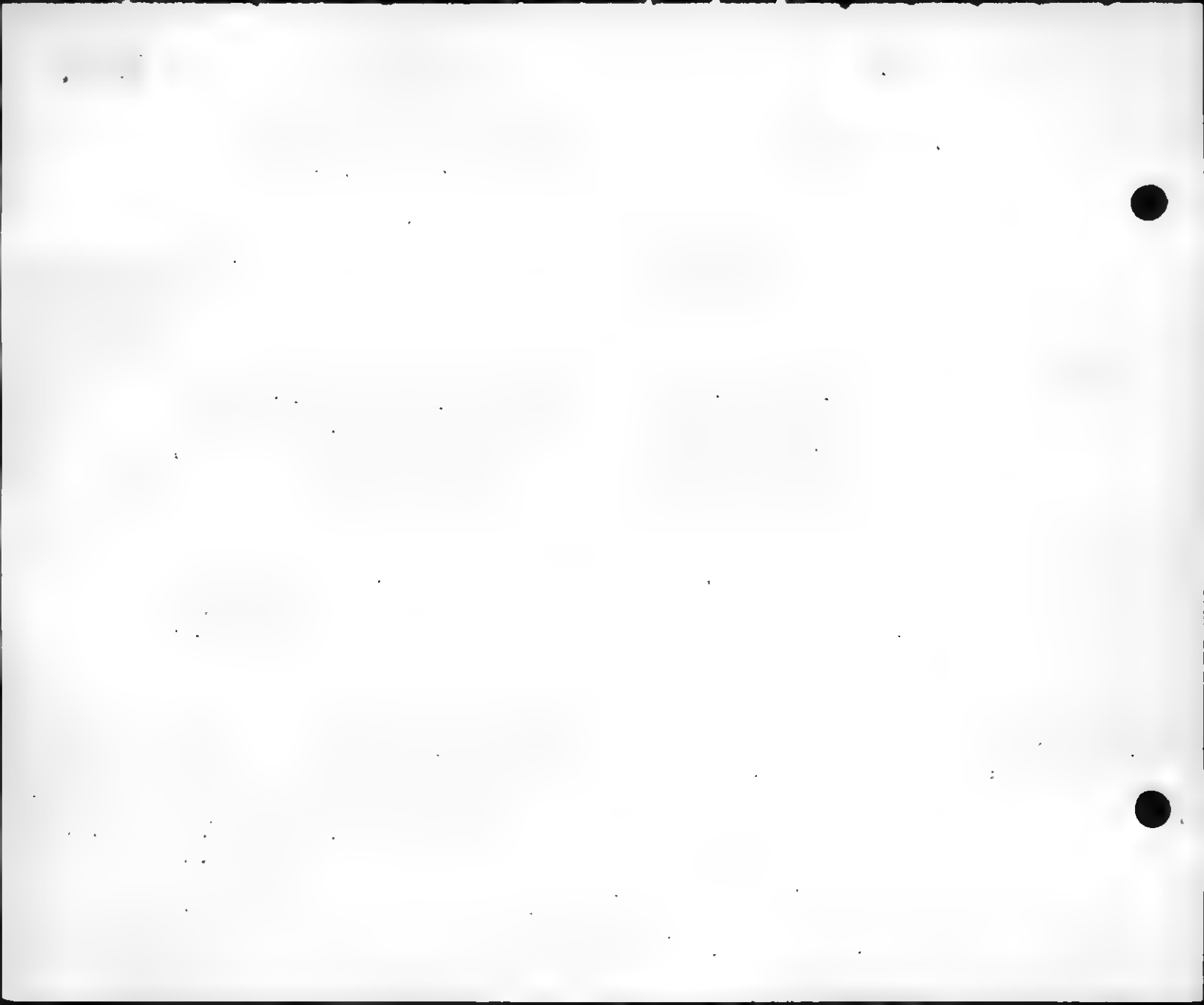




TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
14397 CERTIFICATE OF DEATH 14397										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Greece</u> b. COUNTY <u>Nomos Kojanis</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>29 Days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>					d. STREET ADDRESS <u>Peponia Voiou</u>					
3. NAME OF DECEASED (Type or print) <u>Lambrini (NMN) Kondossi</u>					4. DATE OF DEATH <u>October 2 19 66</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>29 July 1948</u>		9. AGE (in years last birthday) <u>18</u> yrs. IF UNDER 1 YEAR IF FUNERAL 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>	
13. FATHER'S NAME <u>Theodosios Kondossi</u>					14. MOTHER'S MAIDEN NAME <u>Anastasia Karamitoboulou</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>--</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> DUE TO (b) <u>Pulmonary Congestion</u> 36 hours DUE TO (c) <u>Alveolar hemorrhage &amp; parenchymal injury</u> 36 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>circulation</u> <u>Status postoperative Aortic Valve Replacement with extracorporeal/</u>										
20a. ACCIDENT OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>3 Sept.</u> , 19 <u>66</u> , to <u>2 Oct.</u> , 19 <u>66</u> , that <u>XX</u> (we) last saw the deceased alive on <u>2 October</u> 19 <u>66</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Thomas J. Fogarty</u>					22b. DATE SIGNED <u>2 October 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>Thomas J. Fogarty, M.D.</u>					22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>4 October 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON DC.</u>			
24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME</u> ADDRESS <u>2230 12 GEORGIA AVE, NW</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



14398

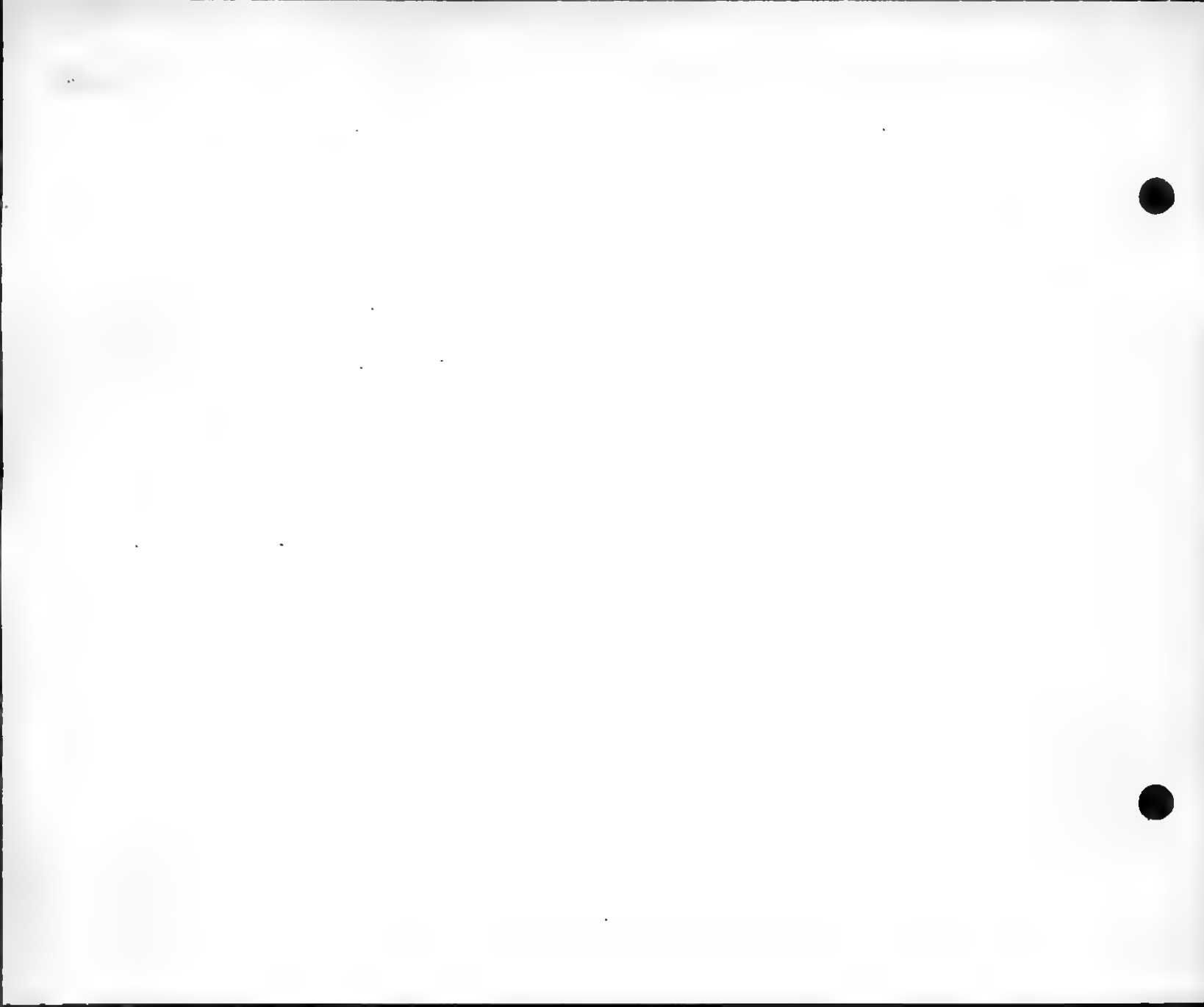
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14298

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF BIRTH COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		2. USUAL RESIDENCE (Where deceased lived first institution Residence before admission) STATE <u>Maryland</u> COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Wash. San + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK</u>		4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-17-82</u>	
9. AGE (in years last birthday) <u>84</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Korkisch</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Mader</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578 201 524</u>	
17. INFORMANT <u>John W. Korkisch</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE <u>Belden R. Reap</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		22. DATE SIGNED <u>OCT. 10, 1966</u>	
23a. BURIAL CREMATION RITUAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 13-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>San Jac. Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>San Jac. Cemetery</u>	
24. FUNERAL DIRECTOR <u>Arthur Nator, 254 Carroll St. N. W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>OCT 13 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14399

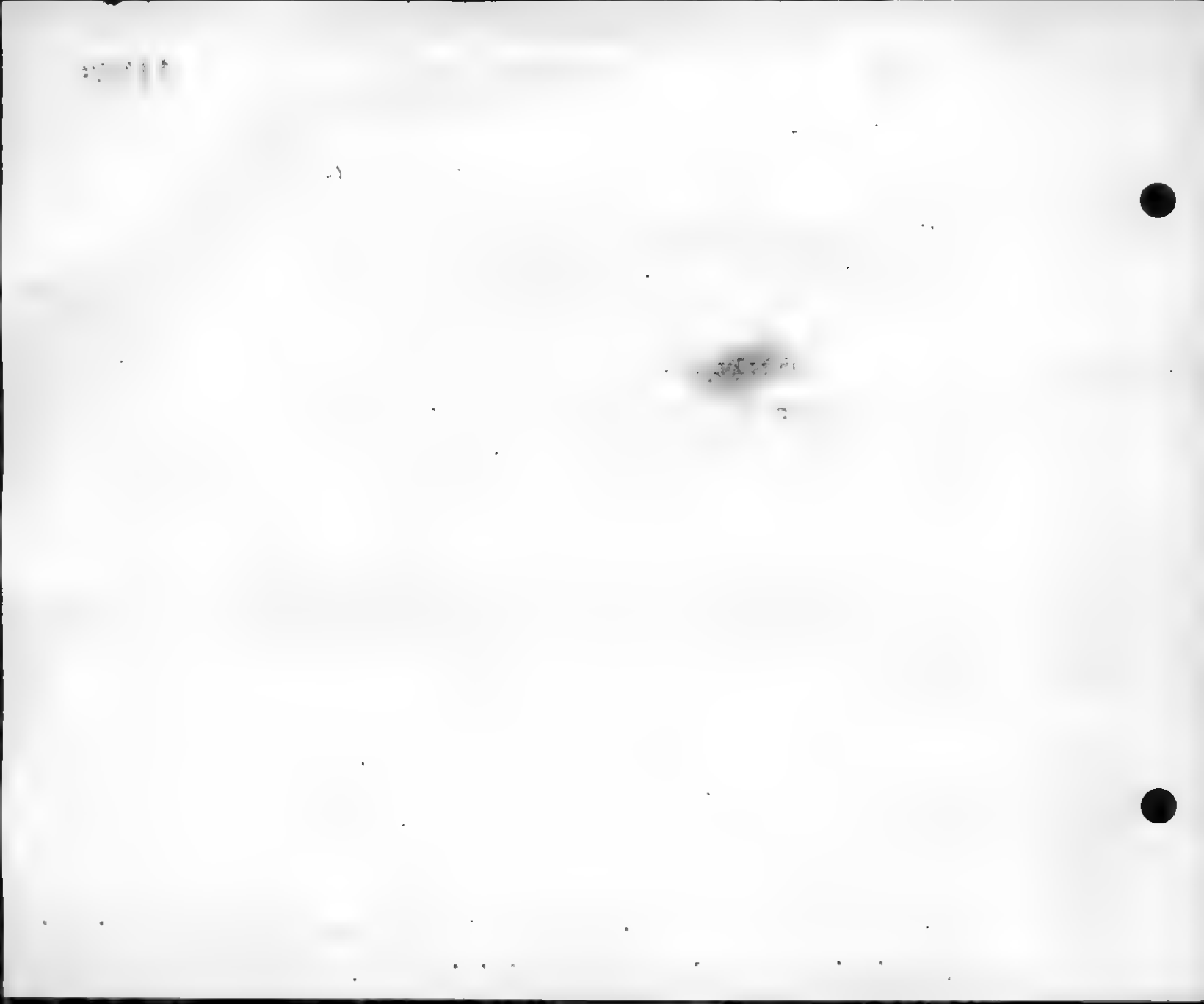
CERTIFICATE OF DEATH

14399

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>(Washington)</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. and Hospital</u>		e. STREET ADDRESS <u>5608 Eastern Ave. N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>JOHANNES KURT KOWNATZKI</u>		4. DATE OF DEATH Month <u>10</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-24-15</u>
9. AGE (in years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not now) <u>Baker - Langley Bakery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
13. FATHER'S NAME <u>Emil Kownatzki</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Hirsch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Hospital records</u>	
17. INFORMANT Address <u>Hospital records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>years</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypothyroidism</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>Oct. 10</u> , 19 <u>66</u> , that (we) last saw the deceased alive on <u>Oct. 10</u> , 19 <u>66</u> , and that death occurred at <u>12:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Norman H. Rubenstein</u> M.D.		22b. DATE SIGNED <u>10/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman H. Rubenstein</u>		22d. ADDRESS <u>6780 N.H. Ave. Tak. Pk., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/11/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>The S. H. Hines Co. Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>OCT 13 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14400

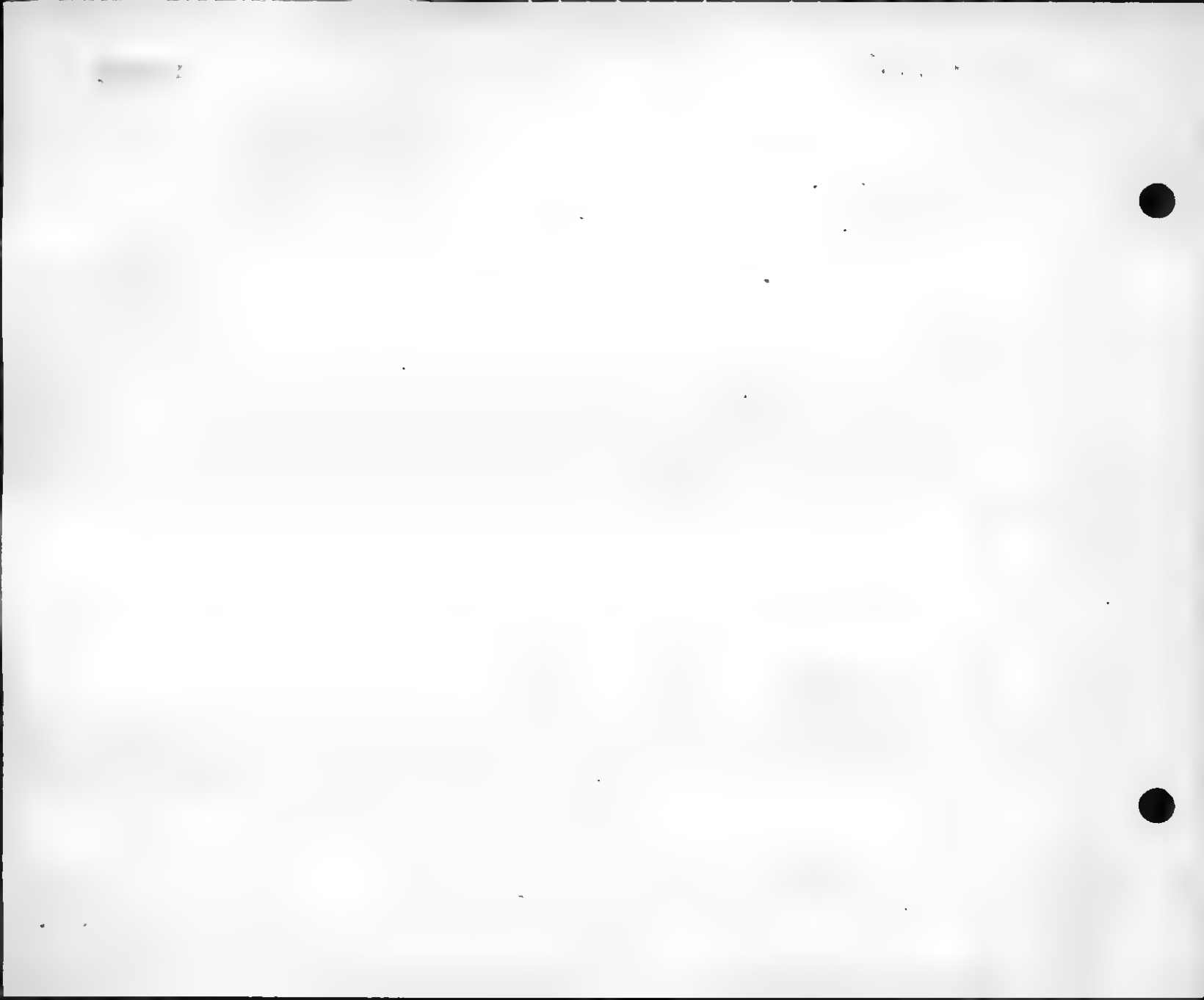
14400

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>237 hrs, 26 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> d. STREET ADDRESS <u>805 LARCH AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RAY</u> Middle <u>—</u> Last <u>KRUEGER</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-11-87</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>NATHAN PASTERNAK</u>		14. MOTHER'S MAIDEN NAME <u>GERTRUDE ZORKOFF</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>CHART - 7600 Carroll Ave, Th Pt, Md</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4341 Acute Congestive failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , <u>1966</u> to <u>10/21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/20</u> , 19 <u>66</u> , and that death occurred at <u>8 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Ernest A. Sarao MD</u>		22b. DATE SIGNED <u>10/21/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAO MD</u>		22d. ADDRESS <u>7006 NEW HAMPSHIRE AVE TAKOMA PARK</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-23-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Va.</u>
24. FUNERAL DIRECTOR <u>Bernard Danzansky and Sons</u>		25a. REC'D BY REGISTRAR <u>Washington DC</u> DATE <u>OCT 24 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14401

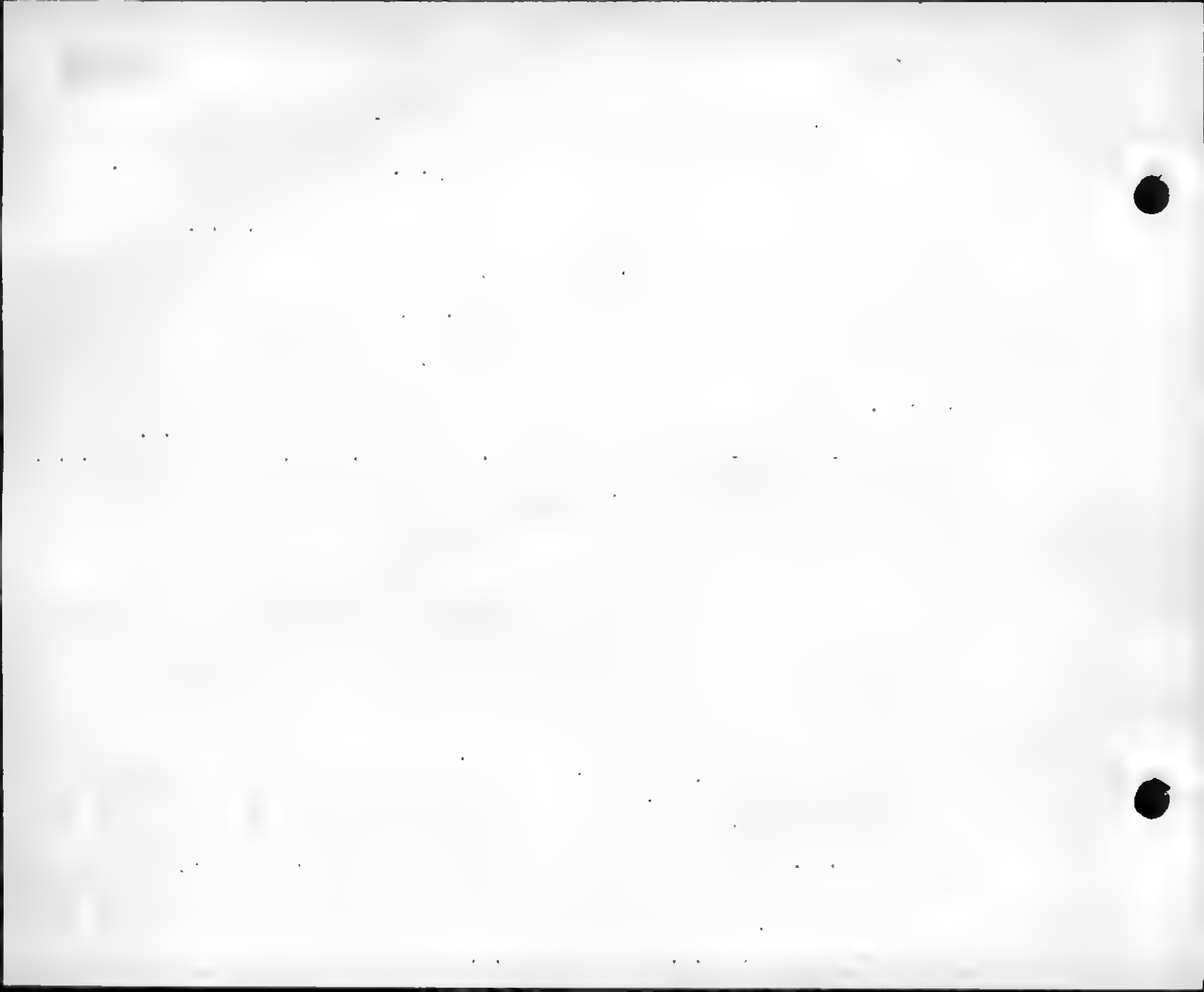
## CERTIFICATE OF DEATH

14401

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>1</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>P.O. Address Sumner, Md. 151</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>			d. STREET ADDRESS <b>5621 Overlea Road, N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Doratha Rutledge KUHN</b>			4. DATE OF DEATH Month Day Year <b>October 6 19 66</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1915</b>	9. AGE (In years last birthday) <b>51 yrs</b>	F UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Pittsburgh, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>James A. Rutledge</b>			14. MOTHER'S MAIDEN NAME <b>Hilda Luther</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>193 05 2053</b>	17. INFORMANT <b>Washington 16</b> Address <b>D.C.</b> <b>Mr. William C. Kuhn, 5621 Overlea Rd. N.W.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Breast, Bilateral, with Plural Metastases</b> <b>110X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (if this hospital) attended the deceased from <b>Oct. 5, 1966</b> , to <b>Oct. 6, 1966</b> that (if we) last saw the deceased alive on <b>Oct. 6, 1966</b> , and that death occurred at <b>405PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>H. E. Ashworth</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>7 October 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>H. E. ASHWORTH, LT MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-10-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>		
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Son</b> ADDRESS <b>5130 Wisconsin Ave., N.W. Washington, D.C.</b>			25a. REC'D BY REGISTRAR DATE <b>OCT 13 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3 should be filed with the State Dept. of Health after death.



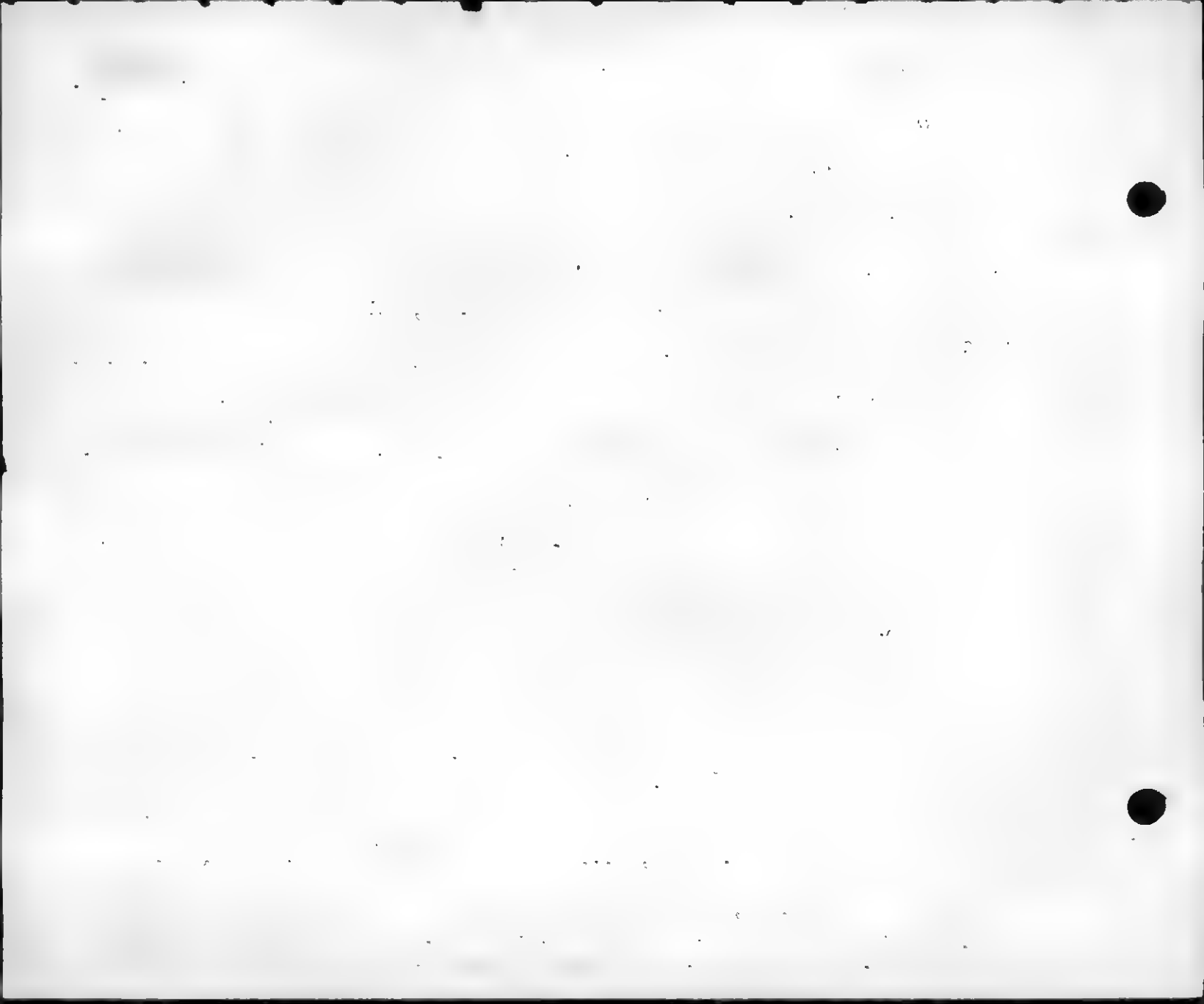
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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14402					14402				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN Id <u>18 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>709 Wayne Avenue</u>					d. STREET ADDRESS <u>709 Wayne Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carrie May Laws</u>		First Middle Last			4. DATE OF DEATH <u>October 18 1966</u>		Month Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sep. 12, 1881</u>		9. AGE (In years last birthday) <u>85 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Frank Weller</u>				14. MOTHER'S MAIDEN NAME <u>Clara Stockslager</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>219-48-1325</u>		17. INFORMANT <u>Mrs. G. Moseley</u>		Address <u>709 Wayne Avenue Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial and respiratory failure</u> <u>4341</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary insufficiency</u> DUE TO (c) <u>Congestive heart failure</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>8-12 months</u> <u>14 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Senility</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 9, 1960</u> to <u>Oct. 18, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct. 18, 1966</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Philip E. Jones</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct. 18, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Philip E. Jones, M.D.</u>				22d. ADDRESS <u>800 Pershing Dr., S.S., Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 21, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Catlett Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Catlett, Virginia</u>			
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

14403

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14403

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admiss on) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u>		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rockville</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6106 Nielwood Dr.</u>		d STREET ADDRESS <u>6106 Nielwood Dr</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Milton Lehman</u>		4 DATE OF DEATH Month Day Year <u>Oct. 13 19 66</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec 24 1917</u>
9 AGE (In years last birthday) yrs <u>49</u>		10 IF UNDER 1 YEAR Months Days Hours Min <u>49</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Pittsburg - Pa</u>	
11 BIRTHPLACE (State or foreign country) <u>Pittsburg - Pa</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>Milton Lehman</u>		14 MOTHER'S MAIDEN NAME <u>Helen Nussbaum</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW II</u>		16 SOCIAL SECURITY NO <u>170-14-8733</u>	
17. INFORMANT Address			
18 CAUSE OF DEATH (Enter on y one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 970.2 DUE TO <u>Coronary Artery Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO <u>Cardiorespiratory failure due to overdose of</u> (c) <u>barbiturate apparently self-administered</u>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18) <u>Deceased apparently took an overdose of a short-acting barbiturate</u>	
20c TIME OF INJURY Month, Day, Year <u>2:00 PM 10/13 19 66</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg etc) <u>Home</u>		20f (City or town) (County) (State) <u>Rockville Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Fear</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. FEAR, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>OCT. 13, 1966</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Wheaton, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b DATE THEREOF <u>10/14/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>West View, Pitt. Pa.</u>		23d LOCATION (City or Town) (County) (State) <u>Pittsburgh, Pa.</u>	
24. FUNERAL DIRECTOR <u>B. Nangany + Sons</u>		ADDRESS <u>3501-14th St. N.W</u>	
25a REC'D BY REGISTRAR <u>Charles Judge</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 17 1966</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Page 3) Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

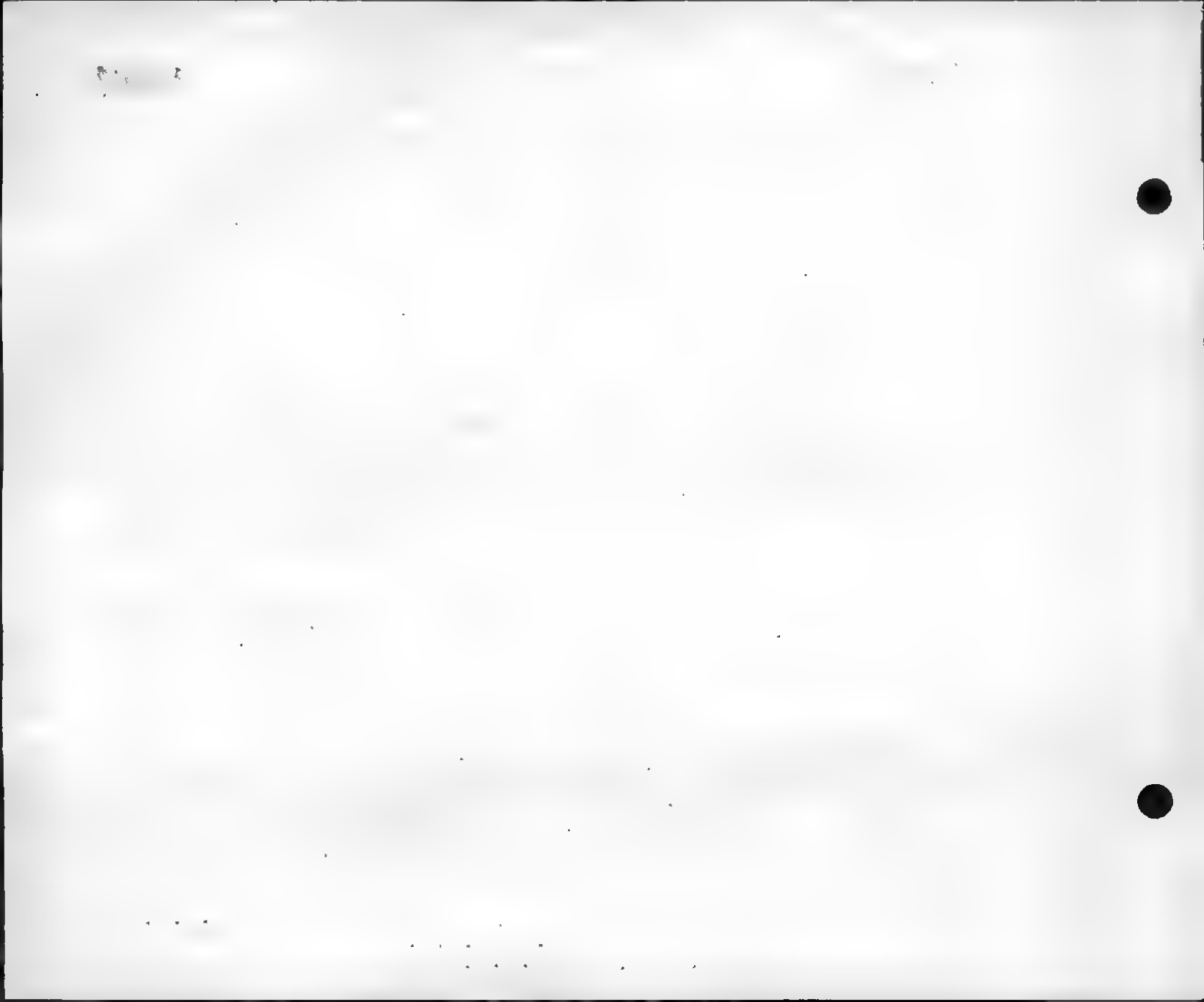
VR A15 (4)  
20 M 1/66

14404

CERTIFICATE OF DEATH

14404

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>2 yrs. 10 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home 11901 Georgia Ave.</u>				d. STREET ADDRESS <u>3016 Tilden St. NN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mabel</u> First <u>B.</u> Middle <u>Leonard</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-29-76</u>	
9. AGE (In years last birthday) <u>89</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>IOWA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOHN WURY</u>			
14. MOTHER'S MAIDEN NAME <u>MARY WILSON.</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>577-66-5894</u>				17. INFORMANT <u>ANNA E. BAINES- 4125-MEADE ST. N.E.</u> Address <u>WASH D.C.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Diabetes</u> (c) <u>None</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Inanition.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>64</u> , to <u>Oct</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Oct 11</u> , 19 <u>66</u> and that death occurred at <u>10</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Belden R. Reap</u> M.D.				22b. DATE SIGNED <u>Oct 11, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>BELDEN R. REAP, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>10-12-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Wash. Medical School / Wash. D.C.</u>	
24. FUNERAL DIRECTOR <u>Joseph Tawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>OCT 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

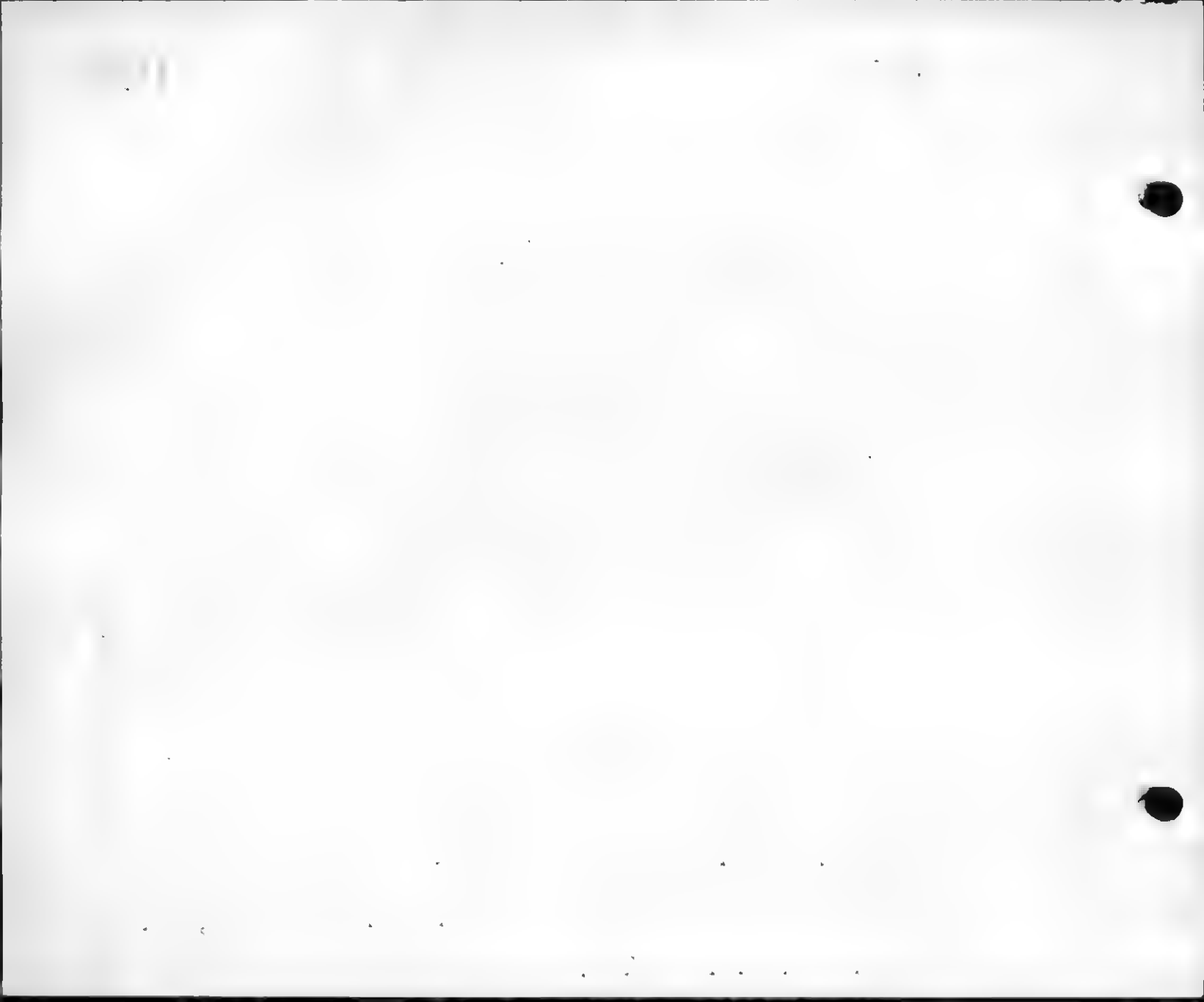
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14405

CERTIFICATE OF DEATH

14405

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>7601 ExETER Road</u>	
3. NAME OF DECEASED (Type or print) <u>E. John</u> First Middle Last		4. DATE OF DEATH <u>10-24</u> 19 <u>66</u> Month Day Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-1900</u> 66 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Publisher-Editor-Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ocean Science News</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse Elias Long</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Kenmuir</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO <u>261-40-7876</u>	
17. INFORMANT <u>Wife - Virginia W.</u> Address <u>Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure, acute and chronic</u> DUE TO (b) <u>Myocardial infarction, remote</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1944</u> to <u>OCT 24, 1966</u> , that (I) (we) last saw the deceased alive on <u>OCT 24 1966</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Leo M. Custis</u> M.D.		22b. DATE SIGNED <u>10-24-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Leo M. Custis</u>		22d. ADDRESS <u>8218 Wisconsin Ave, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-27-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Va</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W. Wash. DC.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>OCT 27 1966</u>	
		25b. REGISTRAR'S SIGNATURE	

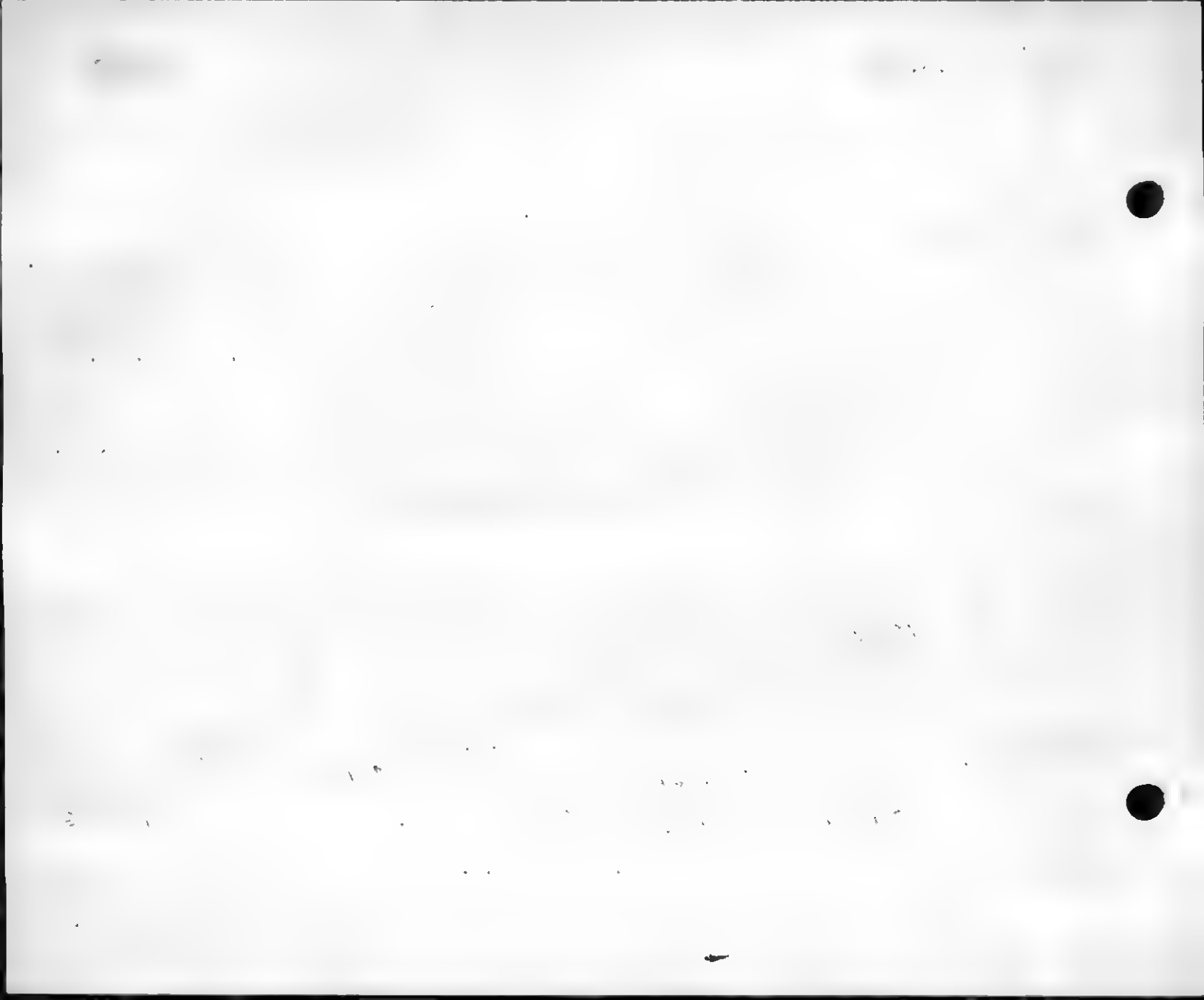


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**14406** **CERTIFICATE OF DEATH** **14406**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Union Bridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Asbury Methodist Home for the Aged, Inc.</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Missouri</b> Last <b>Lynn</b>		4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1877</b>
9. AGE (In years last birthday) <b>89 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>4</b> Days <b>4</b> Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk &amp; kept house</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>McKinstry's Mills, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Franklin Thomas Lynn</b>		14. MOTHER'S MAIDEN NAME <b>Laura Crumpacker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-03-7784</b>	
17. INFORMANT <b>Asbury Methodist Home, Gaithersburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rectovaginal fistula</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/25/63</b> , 19 to <b>10/6/66</b> , 19, that (I) last saw the deceased alive on <b>10/6/66</b> , 19, and that death occurred at <b>4:00 P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry C. Scruggs M.D.</b>		22b. DATE SIGNED <b>10/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry C. Scruggs M.D.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-9-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount View</b>		23d. LOCATION (City, town or county) (State) <b>Union Bridge Md</b>	
24. FUNERAL DIRECTOR <b>Ernest C. Gartner</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 11 1966</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Items 18 & 21 Film 383 11-2 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

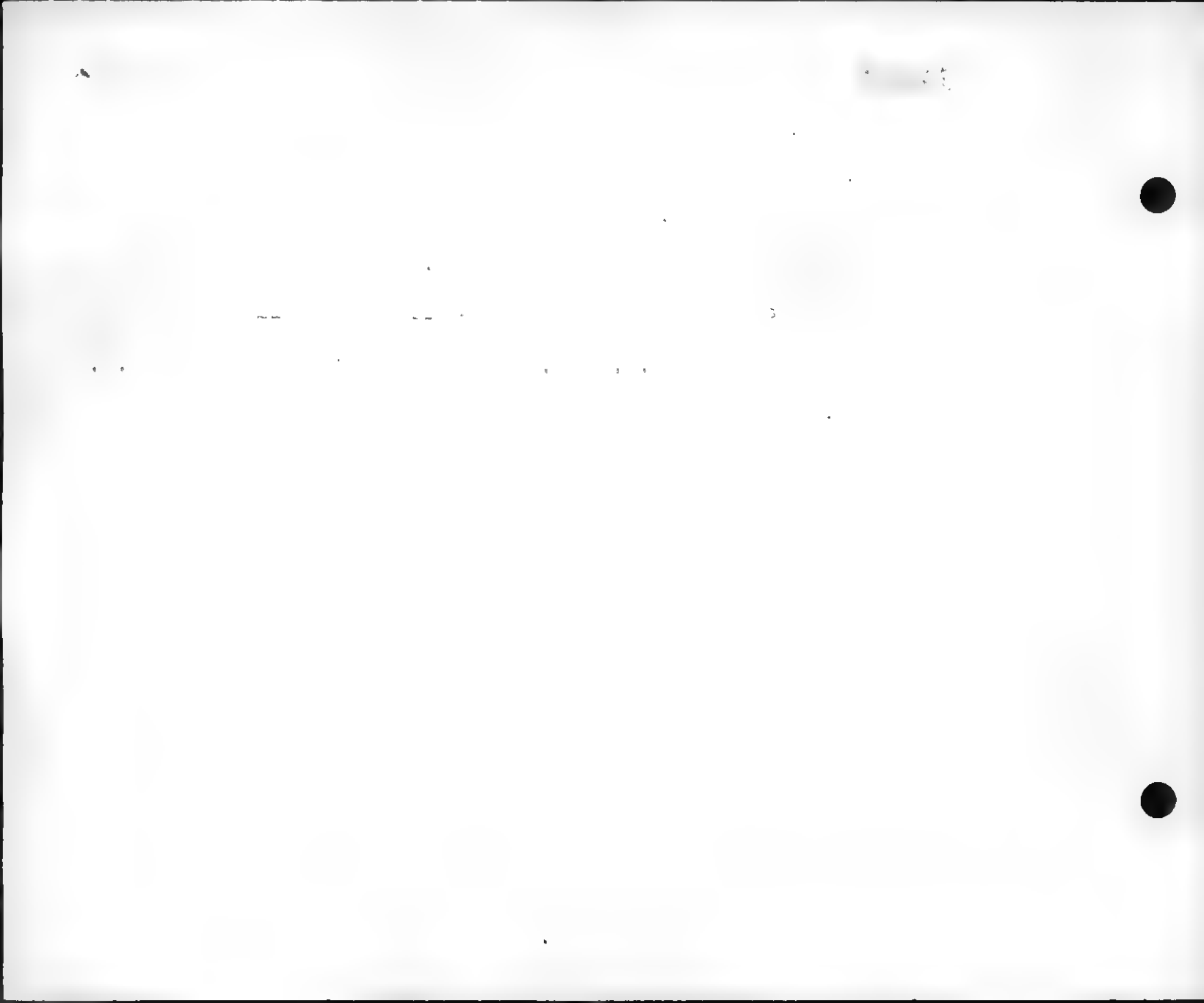
14407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14407

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c LENGTH OF STAY IN 1b <b>29 Min</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital of Silver Spring</b>				d STREET ADDRESS <b>5909-60th Avenue</b>			
3 NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>R.</b> Last <b>MacDonald</b>				4 DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1966</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>Caucasian</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>1920</b> <b>10-17-21</b>	
9 AGE (In years last birthday) <b>46</b> <b>45</b> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Carpenter</b>		10b KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>William MacDonald</b>		14 MOTHER'S MAIDEN NAME <b>Ella Ingram</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Army WWII</b>				16 SOCIAL SECURITY NO		17 INFORMANT <b>Wife (Mrs. Agnes M. MacDonald (above address))</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute coronary insufficiency</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary artery heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office building, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Charles Judge</b>			
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>				22 DATE SIGNED <b>10/29/1966</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>11/2/66</b>		23c NAME OF CEMETERY OR CREMATORY <b>Arl. Nat. Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24 FUNERAL DIRECTOR <b>Nailey's Funeral Home Inc.</b>				ADDRESS <b>1111 Rainier Maryland</b>		25a REC'D BY REGISTRAR DATE <b>NOV 4 1966</b>	
				25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

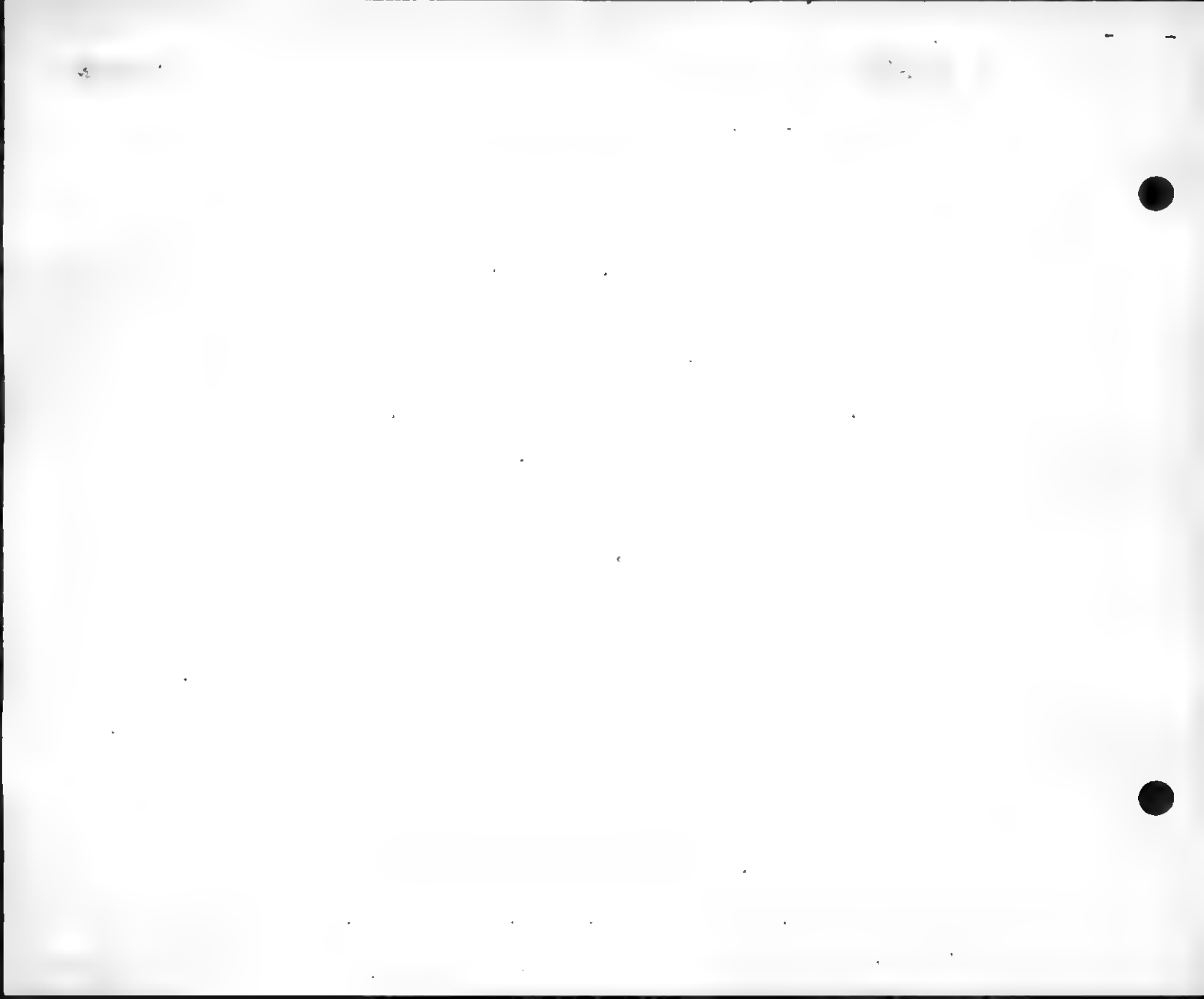
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14408

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14408

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1d <u>??</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10401 Grosvenor Pl.</u>		d. STREET ADDRESS <u>Rockville</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>E.</u> Last <u>MANTZ</u>		4 DATE OF DEATH Month <u>Oct</u> Day <u>2</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 3 1912</u>
9 AGE (In years last birthday) yrs <u>54</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>29</u> Hours <u></u> Min <u></u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11 BIRTHPLACE (State or foreign country) <u>Richmond, Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>William A. Edelblut</u>		14 MOTHER'S MAIDEN NAME <u>Grace L. Bradley</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>Unknown</u>	
17 INFORMANT <u>G. Earl Mantz - Husband - Same as Item #2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries, Multiple severe</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Fall, seventeen stories</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Jumped from 17th Floor of Apartment.</u>	
20c TIME OF INJURY Month Day Year <u>10:30 a.m. 10/2 1966</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Apartment.</u>		20f (City or town) (County) (State) <u>Rockville Mont Md.</u>	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>10/3/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b DATE THEREOF <u>Oct. 4, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u>
24 FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 7 1966</u>	





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

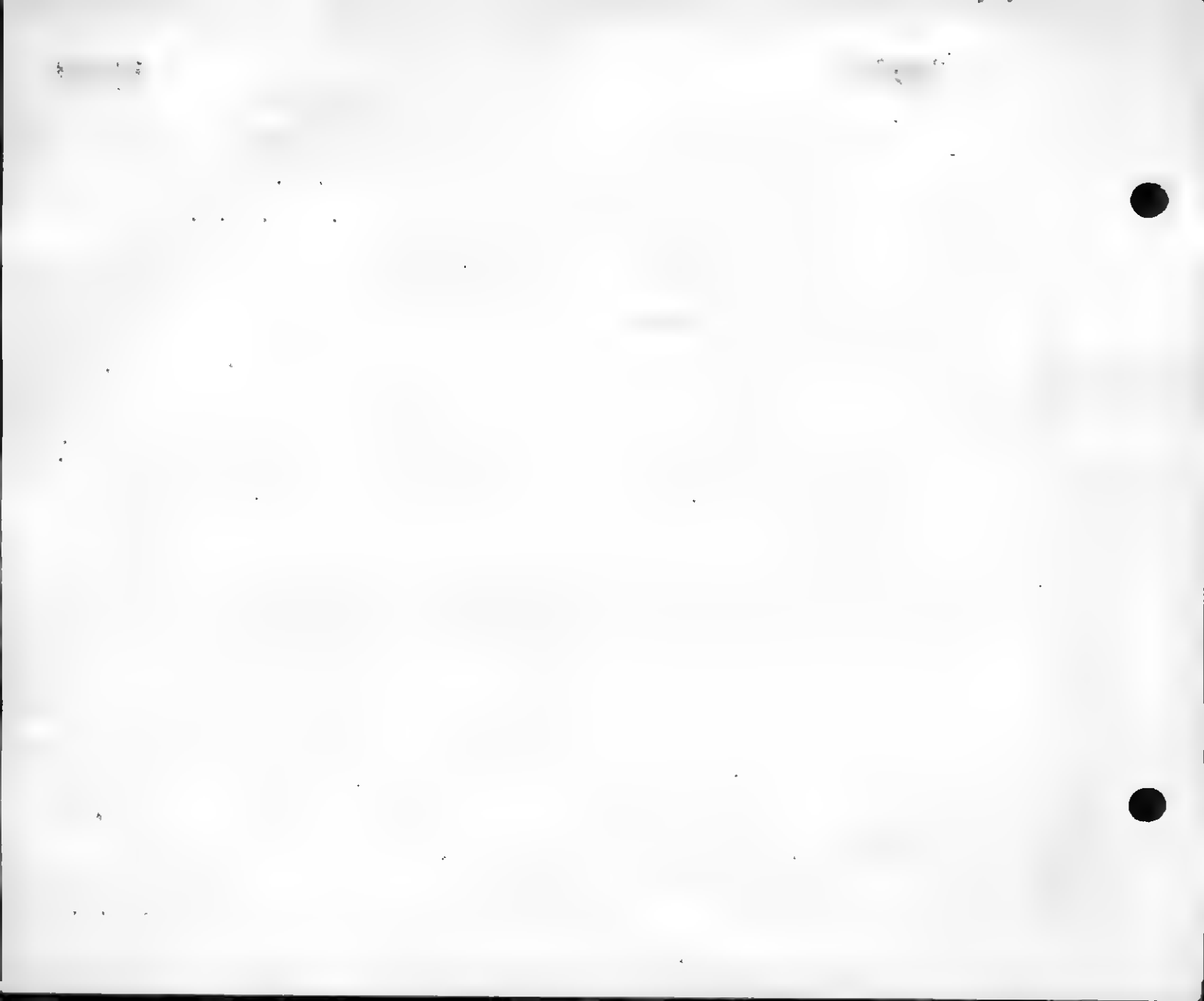
## CERTIFICATE OF DEATH

14409

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. LENGTH OF STAY IN 1b <u>2 Months 9 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Elizabeth</u> Last <u>Lyons</u>		4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW <input type="checkbox"/>		8. DATE OF BIRTH <u>1/20/02</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Keeper</u>		12. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
13. BIRTHPLACE (County & State, or foreign country) <u>New York City, N.Y.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>George Lyons</u>		16. MOTHER'S MAIDEN NAME <u>Anne Barry</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO <u>  </u>	
19. INFORMANT <u>Gertrude Lyons</u>		20. ADDRESS <u>283 West 11th St. New York City, N.Y.</u>	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Postnecrotic CIRRHOSIS</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>D. obles Malitus</u>		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>  </u>	
24a. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		24b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		24d. (City or town) (County) (State) <u>  </u>	
25. I certify that (I) (this hospital) attended the deceased from <u>Aug 2</u> , 19 <u>66</u> , to <u>October 9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 9</u> , 19 <u>66</u> , and that death occurred at <u>1200 PM</u> , from causes and on the date stated above			
26a. SIGNATURE <u>Boris Rabkin</u>		26b. DATE SIGNED <u>10/9/66</u>	
26c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		26d. ADDRESS <u>1019 Univ. Blvd E S.S.</u>	
27a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		27b. DATE THEREOF <u>10/11/66</u>	
27c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		27d. LOCATION (City or Town) (County) (State) <u>New York City, N.Y.</u>	
28a. FUNERAL DIRECTOR <u>The A.H. Hines Co 2901 14th St. N.W.</u>		28b. ADDRESS <u>  </u>	
28c. REC'D BY REGISTRAR <u>  </u>		28d. REGISTRAR'S SIGNATURE <u>  </u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
20 M 1/66



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14410

## CERTIFICATE OF DEATH

14410

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>15 hours</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>201 Congressional Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Pearl C. Mason</u>		4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/17/15</u>
9. AGE (In years last birthday) <u>51</u> yrs		IF UNDER 1 YEAR Months Days Hours Mnt.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>New York N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Slikeman</u>		14. MOTHER'S MARDEN NAME <u>May Shanko</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sandra Thompson Caldwell</u>		Address <u>259 Congressional</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> DUE TO <u>MITRAL INSUFFICIENCY, MITRAL STENOSIS, AIO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CHRONIC RHEUMATIC HEART DISEASE WITH AS</u> DUE TO (c) <u>RHEUMATIC FEVER</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u> <u>30 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>  </u> , to <u>10/28/66</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>10/28/66</u> , 19 <u>  </u> , and that death occurred at <u>2:38</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Frederick S Caldwell</u>		22b. DATE SIGNED <u>10/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S CALDWELL</u>		22d. ADDRESS <u>7000 BLOD</u> <u>ROCKVILLE MARYLAND</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-31-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 1 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14411

CERTIFICATE OF DEATH

14411

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>29 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. STREET ADDRESS <b>2105 Oakwood Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Jose</b> Middle <b>MAURICIO</b> Last <b>MAURICIO</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>21</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1882</b>
9. AGE (In years last birthday) yrs <b>84</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>66</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>private home</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Philippine Islands</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>579-48-7733A</b>	
17. INFORMANT <b>Hillcrest</b>		Address <b>Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal hemorrhage</b> DUE TO (b) <b>510X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Perforation urinary bladder with recto-vesical fistula</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Perforation urinary bladder with recto-vesical fistula</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>Sept. 22, 19 66</b> , to <b>Oct. 21, 19 66</b> , that (X) (we) last saw the deceased alive on <b>Oct. 2, 19 66</b> , and that death occurred at <b>4:55 A. M.</b> from causes on and on the date stated above			
22a. SIGNATURE <b>L. A. Jones, M. D.</b>		22b. DATE SIGNED <b>21 Oct. 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. A. Jones, M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 25, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. ADDRESS <b>Simmons Brothers Funeral Home</b>		25a. REC'D BY REGISTRAR <b>OCT 24 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>1661 Goodhope Road, S.E. Washington, D. C.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

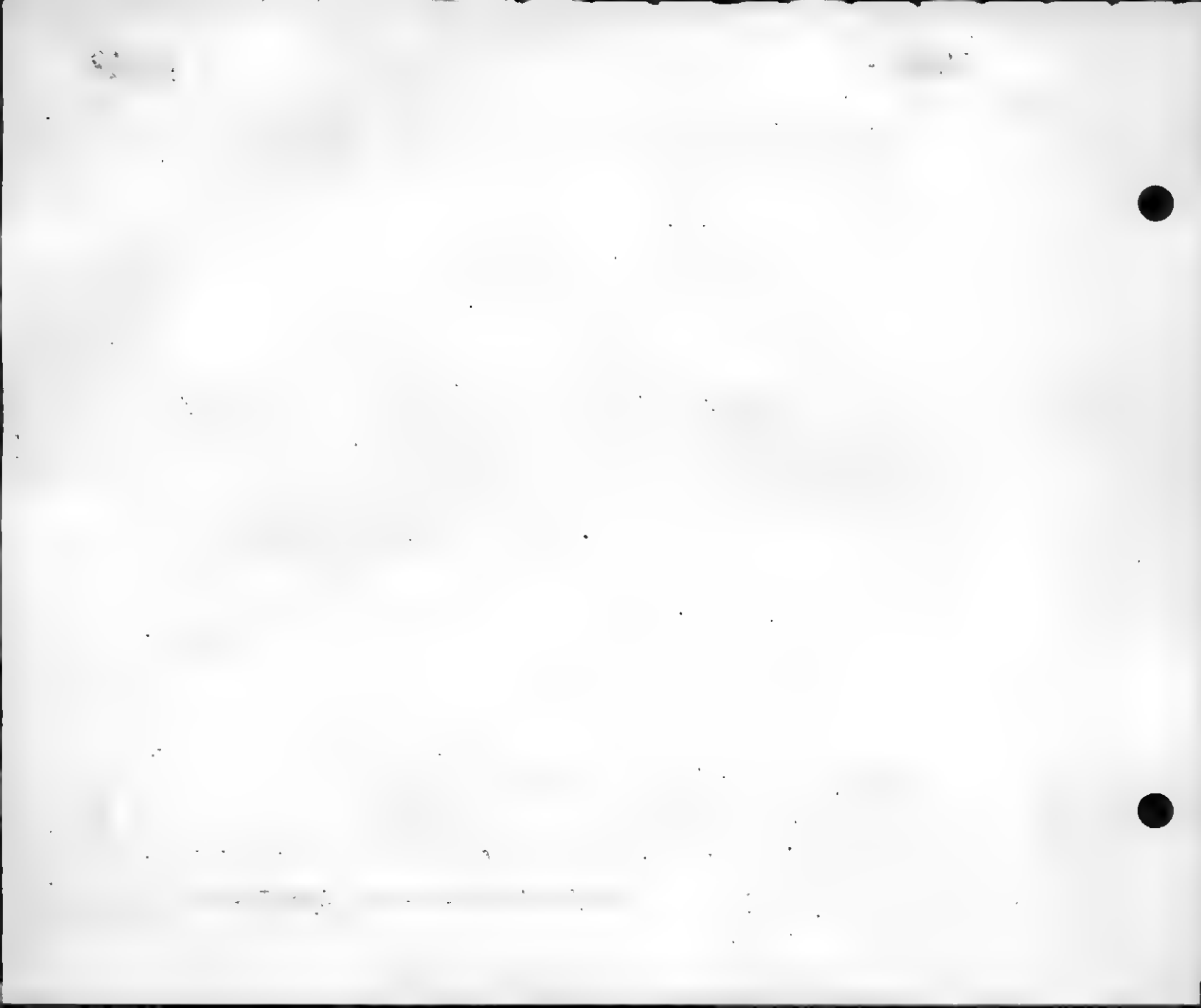
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14412

## CERTIFICATE OF DEATH

14412

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN - MD.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>ELEN L. McDONALD</u>				4. DATE OF DEATH <u>10-6-1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-07</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES ROBINSON</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE FOWLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Edward B. McDonald</u> Address <u>Seneca Rd. Germantown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MESENTERIC INFARCTION, EMBOLIC</u> DUE TO (b) <u>RHEUMATIC HEART DISEASE, MITRAL STENOSIS</u> DUE TO (c) <u>DECADES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CONGENITAL HYPPLASIA OF THE LOWER ABDOMINAL AORTA</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-21</u> , 19 <u>66</u> , to <u>10/6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/6</u> , 19 <u>66</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Pollen</u>				22b. DATE SIGNED <u>10/7/66 md.</u>		22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>	
22d. ADDRESS <u>10400 CONNECTICUT AVE, KENSINGTON</u>		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Oct 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY, WASHINGTON, D.C.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Arthur Valters</u>		24a. ADDRESS <u>254 E. ...</u>		24b. REC'D BY REGISTRAR <u>Charles Judge</u>		24c. REGISTRAR'S SIGNATURE	
DATE <u>OCT 11 1966</u>							





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14413

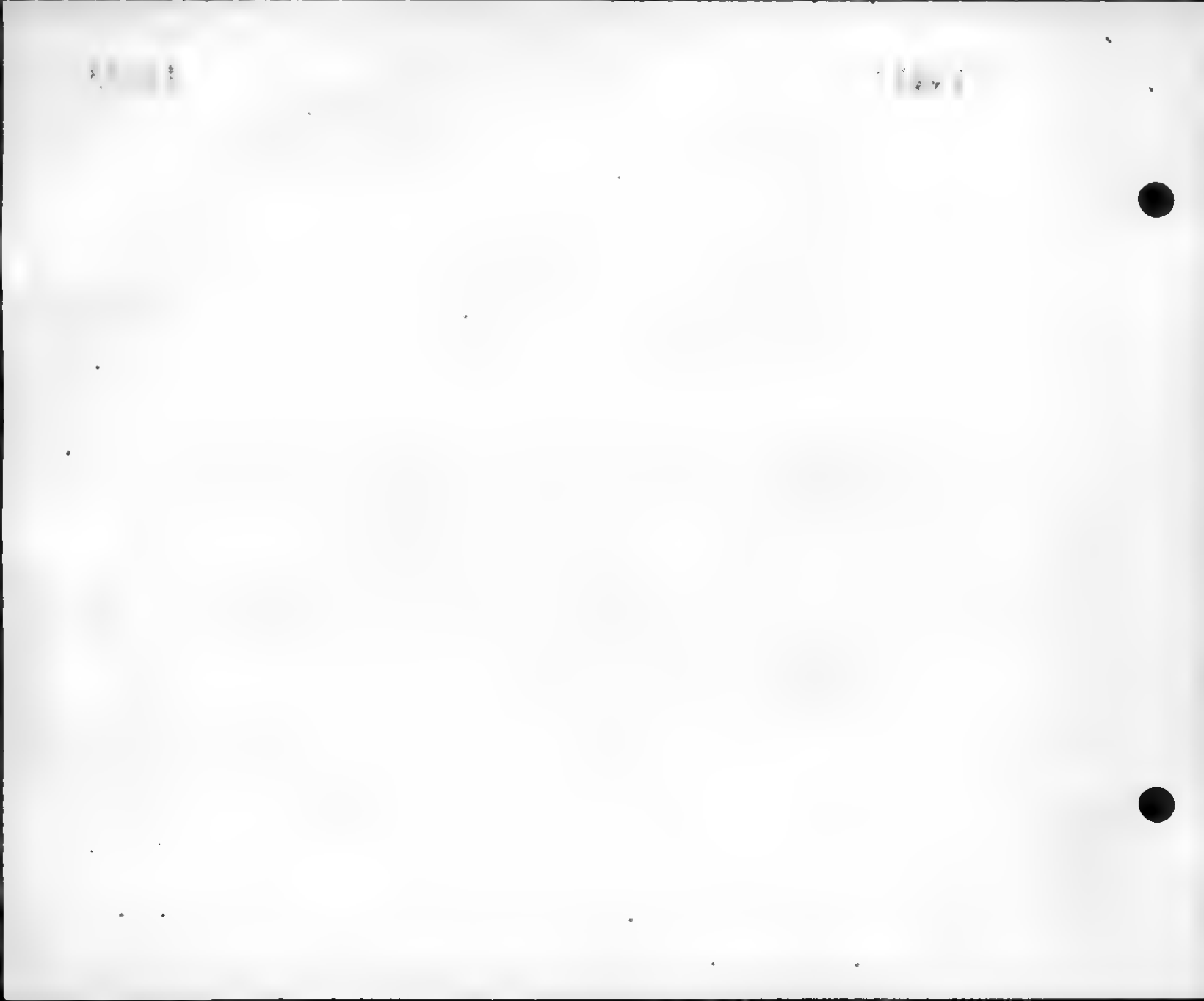
CERTIFICATE OF DEATH

14413

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admiss on) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not n hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>9600 Forest Road</b>	
3. NAME OF DECEASED (Type or print) <b>Sister Edward McHugh</b>		4. DATE OF DEATH Month <b>11</b> Day <b>31</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1883</b>
9. AGE (In years last birthday) <b>82</b> yrs		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>30</b> hours <b></b> Min. <b></b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Catholic Sister</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ireland</b>		12. CIT ZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Patrick McHugh</b>		14. MOTHER'S MAIDEN NAME <b>Nora Cullinane</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ursuline Convent Records</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> DUE TO (b) <b>Carcinomatosis, genit</b> DUE TO (c) <b>Carcinoma, ascending Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs</b> <b>2 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March, 1956</b> , to <b>March, 1966</b> , that (I) (we) last saw the deceased alive on <b>11/30 1966</b> , and that death occurred at <b>2:50 p.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Charles Salvatore M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>10/31/66</b>
22c. PHYSICIAN'S NAME (Type) <b>CHARLES SALVARESE, M.D.</b>		22d. ADDRESS <b>11625 Rockville Pike Rockville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-3-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 1 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



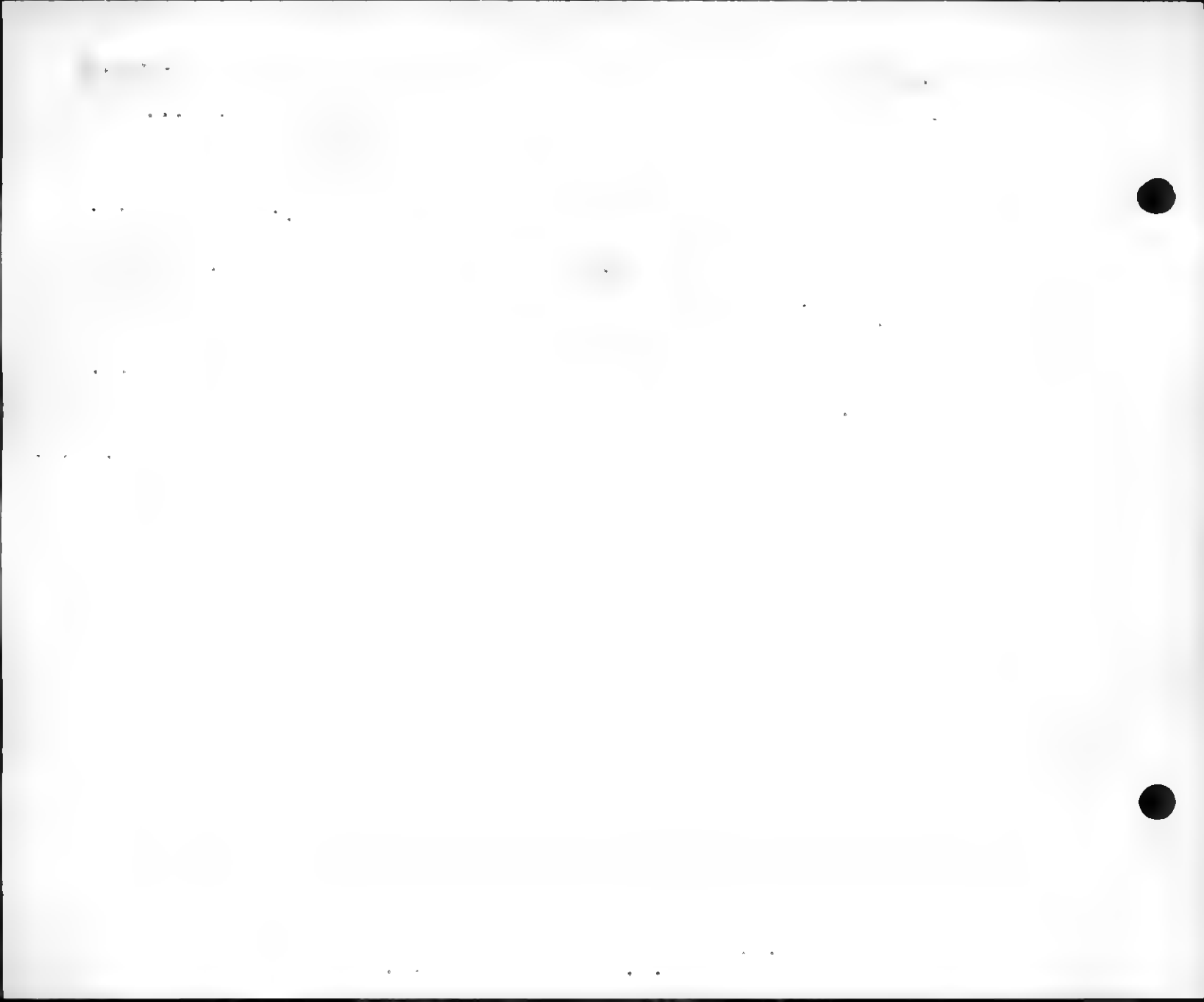
**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film 383 12-19-66 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 2 Film G382 11/17/66 mh

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH o COUNTY <u>Montgomery</u>		2 USUAL RESIDENCE (Where deceased, verify institution. Residence before admission) o STATE <u>Maryland</u> COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1551 Newton Street N.E.</u> <u>Hyattsville, D.C.</u>	
3 NAME OF DECEASED (Type or print) <u>Maggie Young McLean</u>		4 DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/9/69</u>
9. AGE (In years last birthday) <u>97</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wesley D. Young</u>	
14. MOTHER'S MAIDEN NAME <u>Armina Ivy</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO <u>579-60-0911</u>		17. INFORMANT <u>John H. McLean, 3506 16th St. N.E.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>following a fall</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Deceased fell in Nursing Home</u>	
20c. TIME OF INJURY Month, Day, Year Hour: <u>  </u> am <u>  </u> pm <u>10-22-66</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off campus, etc.) <u>Nursing Home</u>	20f. (City or town) (County) (State) <u>Hyattsville Pr. Geo. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>10/31/1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County)	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/2/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> <u>2901 14th St. N.W. Washington, D.C.</u>		25. REC'D BY REGISTRAR <u>NOV 3 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



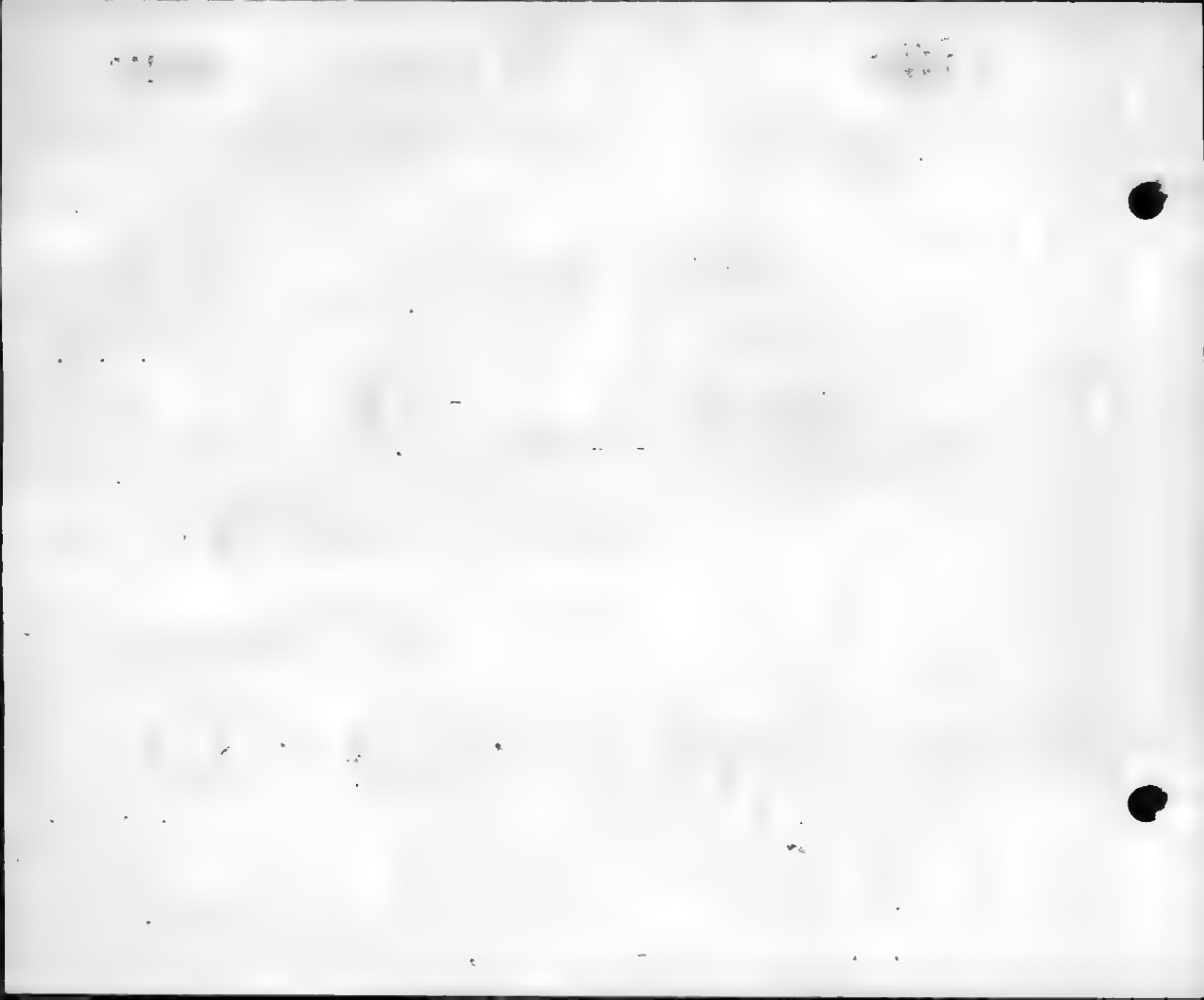
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**14415** **CERTIFICATE OF DEATH** **14415**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4220 Everett Street</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>4220 Everett Street</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Genevieve</b> Middle <b>Nickel</b> Last <b>Meese</b>		4. DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1894</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Illinois</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frederick Nickel</b>		14. MOTHER'S MAIDEN NAME <b>- Jordan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>578-14-7388</b>	
17. INFORMANT <b>Norman S. Meese</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>10 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-15-1966</b> to <b>10-8-1966</b> , that (I) (we) last saw the deceased alive on <b>9-15-1966</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stephen W. DeJeter</b>		22b. DATE SIGNED <b>10-8-1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>STEPHEN W. DEJETER</b>		22d. ADDRESS <b>6719 W. ZENSON LANE, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/11/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>The S. H. Hines Company- Washington, DC</b>		25a. REC'D BY REGISTRAR <b>OCT 11 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14416

CERTIFICATE OF DEATH

14416

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DIST. OF COL.</b> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>18 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>LOUISE</b> Last <b>MENK</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-23-83</b>
9. AGE (In years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>Rudolph MENK</b>		14. MOTHER'S MAIDEN NAME <b>ELISE FISCHER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>- - -</b>	
17. INFORMANT <b>HOSPITAL RECORDS - W.S.H.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary atherosclerosis Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Poss. G.I. tract Malignancy, Septicemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-19, 1966</b> to <b>10-7, 1966</b> that (I) (we) last saw the deceased alive on <b>10-7, 1966</b> and that death occurred at <b>5:35 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Isidore B. Cushman</b> M.D.		22b. DATE SIGNED <b>10-7-66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>?</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>10-10-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory Suitland, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>1120 Wisconsin Ave. N.W. Wash. D.C.</b>		25a. RECD BY REGISTRAR <b>DATE OCT 13 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1111





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14417

14417

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ashley Cross Hospital</u>		d. STREET ADDRESS <u>1213 Harding Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Anita</u> Middle <u>Jean</u> Last <u>Merson</u>		4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 6, 1906</u>
9. AGE (n years last birthday) yrs. <u>60</u>		10. IF UNDER 1 YEAR Months <u>13</u> Days <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William E. Merson</u>		14. MOTHER'S MAIDEN NAME <u>Linda Jean Schell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Atelectasis</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>Prematurity</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-6</u> , 19 <u>66</u> , to <u>10-6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-6</u> , 19 <u>66</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Carl Silverman</u>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>10-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Carl Silverman</u>		22d. ADDRESS <u>12601 EVANSTON ST. ROCKVILLE, Md.</u>	
23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

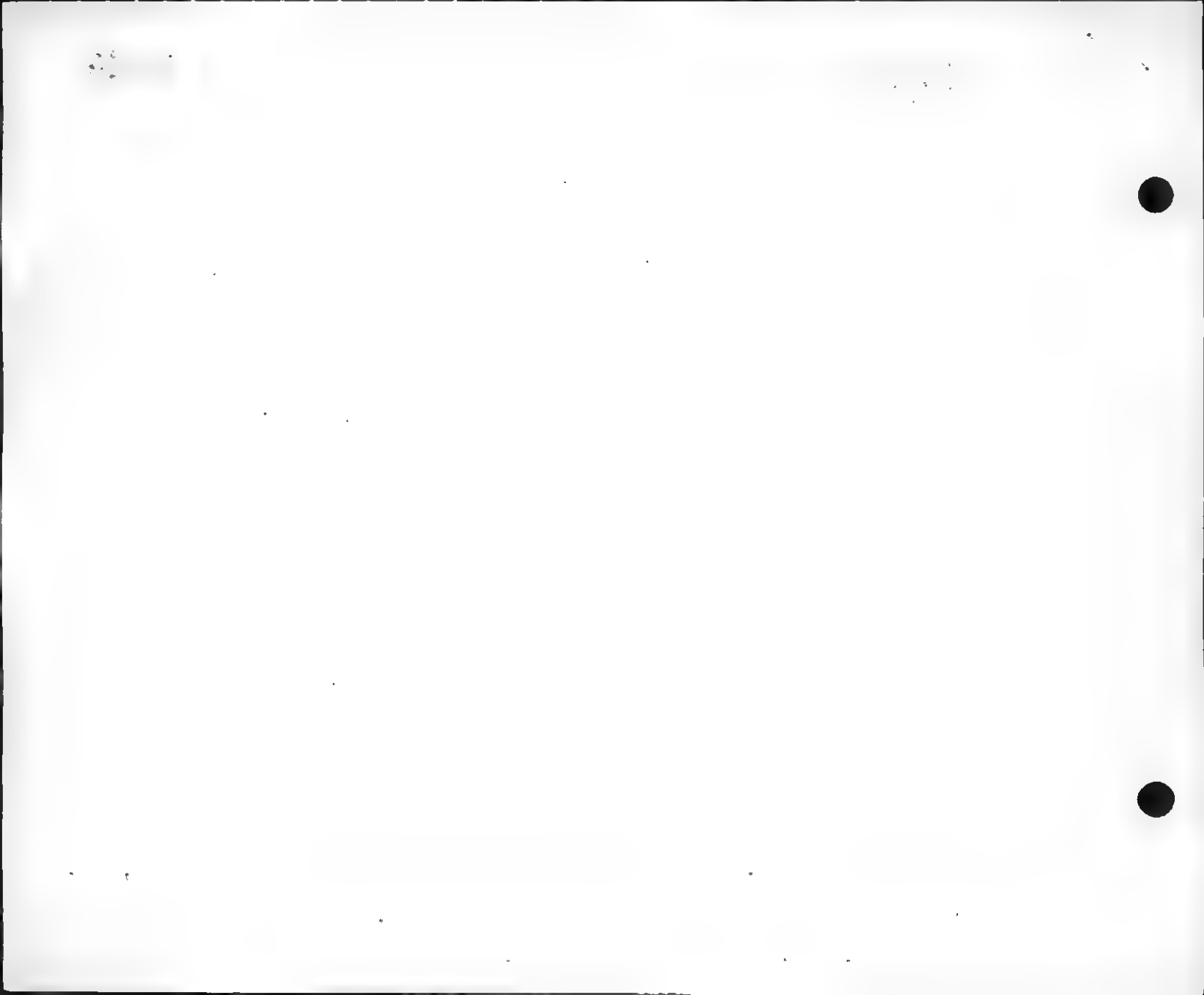
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14418

14418

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>4904 ASBURY LANE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>HENRY IRWIN METZ</u>		4. DATE OF DEATH <u>Oct. 26 1966</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/17/04 62 yrs</u>
9 AGE (In years, last birthday) <u>62</u>		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11 IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Radio Eng</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NASA</u>	
11 BIRTHPLACE (State or foreign country) <u>Penn.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Frederick Metz</u>		14. MOTHER'S MAIDEN NAME <u>Mary Blatt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>577-56-6840</u>	
17 INFORMANT <u>Wife Rose Metz (Home use above)</u>		Address <u>(Home use above)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Burns, 2nd and 3rd degree, 61% body area</u> 7140 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>7140</u> (c) <u>7140</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Can of charcoal lighter, ignited exhaled, igniting clothing</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:00 p.m. 10/22 1966</u>		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> of work <u>Home</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Home</u>
20f. (City or town) <u>Bethesda</u> (County) <u>Mont.</u> (State) <u>Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>10/27/66</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>Bethesda, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>10-29-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	
23d. LOCATION (City or Town) <u>Silver Spring, Maryland</u> (County) <u>Md.</u> (State) <u>Md.</u>		24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Md.</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 1 1966</u>			



14419

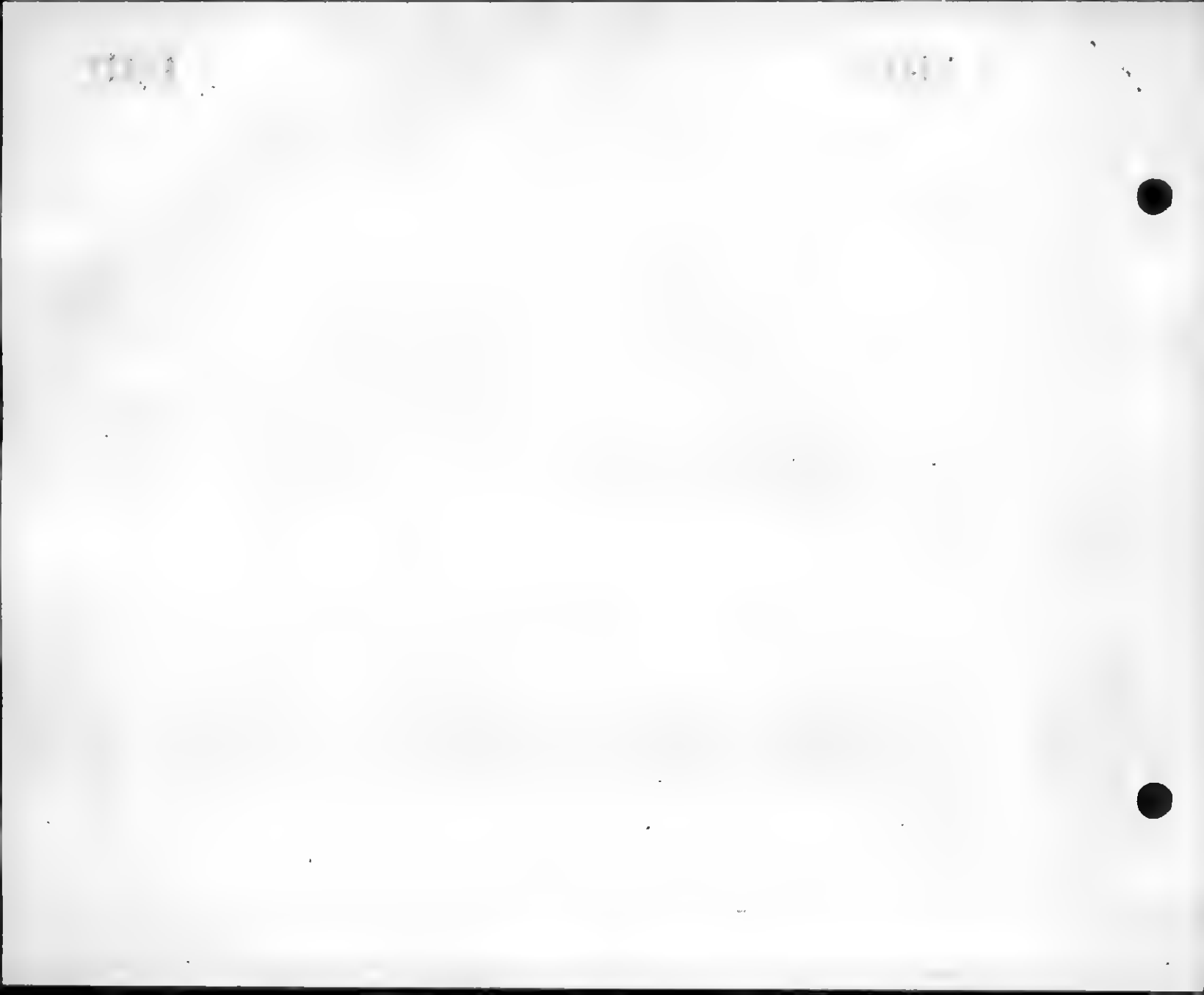
# CERTIFICATE OF DEATH

14419

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Virginia</u> b COUNTY		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>49 Days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mc Lean</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Maryland</u>			d STREET ADDRESS <u>6518 Dryden Drive</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carl Ernest MILLER</u>			4. DATE OF DEATH Month Day Year <u>October 15 19 66</u>		
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>16 July 1908</u>		9. AGE (In years last birthday) <u>58</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronics Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Alexander, North Carolina USA</u>	
13. FATHER'S NAME <u>Obe Miller</u>			14. MOTHER'S MAIDEN NAME <u>Myrtle Teague</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1925-1955</u>		16. SOCIAL SECURITY NO. <u>227-48-8298</u>		17. INFORMANT <u>6518 Dryden Drive Mrs. Thelma Miller Mc Lean, Virginia</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma with wide spread metastases</u> <u>11 21</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6 September 19 66</u> , to <u>15 October 1966</u> , that (I) (we) last saw the deceased alive on <u>15 October 19 66</u> , and that death occurred at <u>935A</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>William L. Brannon, Jr.</u>			22b. DATE SIGNED <u>17 October 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>William L. Brannon, Jr. LCDR MC</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>10-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>
23d. LOCATION (City or Town) <u>Arlington</u>			23e. (County) <u>Virginia</u>		23f. (State)
24. FUNERAL DIRECTOR <u>R.A. Pumphrey Funeral Home Bethesda, Maryland</u>			25a. REC'D BY REGISTRAR DATE <u>OCT 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film 3501 10/13/66 mh

14420

CERTIFICATE OF DEATH

14420

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY in 1b <b>6 days.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>			d. STREET ADDRESS <b>621 N. Frederick Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Esther</b> Middle <b>Mae</b> Last <b>Miller</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>6</b> Year <b>19 66</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5-29-07 1900</b>		9. AGE (In years lost birthday) <b>66</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charles Earp</b>			14. MOTHER'S MAIDEN NAME <b>Lou Jefferson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-52-9524</b>		17. INFORMANT <b>Montgomery Gen. Hospital</b> Address <b>Olney, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>From abdominal aneurysm of</b> DUE TO (c) <b>undetermined source</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic Mellitus - Alacidity</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o m. p m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1</b> , 19 <b>66</b> , to <b>Oct 6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Oct 5</b> , 19 <b>66</b> , and that death occurred at <b>5:15 am</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Dr. A. D. Bonifant</b>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. D. Bonifant</b>			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-8-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>McKormick</b>	
		23d. LOCATION (City or Town) <b>Germanstown montg md</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Ernest C. Gartner</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b>		
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
			DATE <b>OCT 10 1966</b>		

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100





FOR STATE  
HEALTH DEPT.

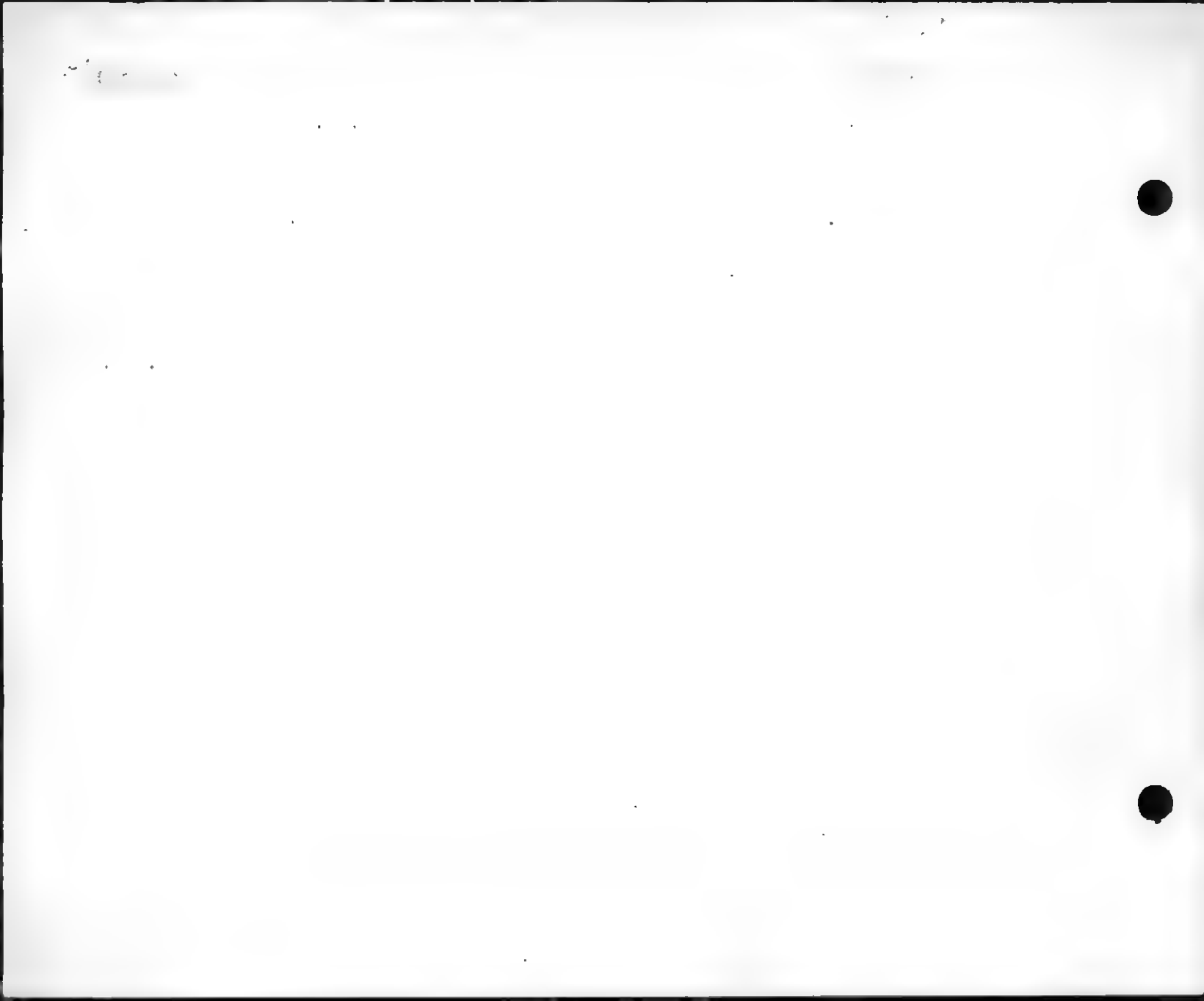
14421

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14421

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>MONTGOMERY</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c LENGTH OF STAY IN 1b <b>23 days/11hrs.</b>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		d STREET ADDRESS <b>429 Butternut St. N. W.</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Bickel</b> Last <b>Miller</b>		4 DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1966</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3-24-75</b>	9 AGE (In years last birthday) <b>91</b> yrs	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>WILLIAM BICKEL</b>		14 MOTHER'S MAIDEN NAME <b>FREDERICKA APFELBACH</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>167-05-1243</b>		17 INFORMANT Address <b>Hospital Records 7600 Carroll Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral pulmonary embolus</b> <b>465x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>arising from left leg.</b> DUE TO (c) <b></b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)		20g (County)		20h (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL EXAMINER'S NAME (Type) <b>BELODEN R. REAP, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) <b>Oct. 3, 1966</b>		22. DATE SIGNED			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Oct-6-1966 Voegtlay</b>		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY <b>Washington Co. Cemetery</b>	
23d LOCATION (City or town) <b>Bethesda</b>		23e (County) <b>Montgomery</b>		23f (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Arthur Walters</b>		ADDRESS <b>2514 Carroll St.</b>		25a REC'D BY REGISTRAR <b>Charles J. J.</b>	
DATE <b>OCT 6 1966</b>		25b REGISTRAR'S SIGNATURE <b>Charles J. J.</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14422

## CERTIFICATE OF DEATH

14422

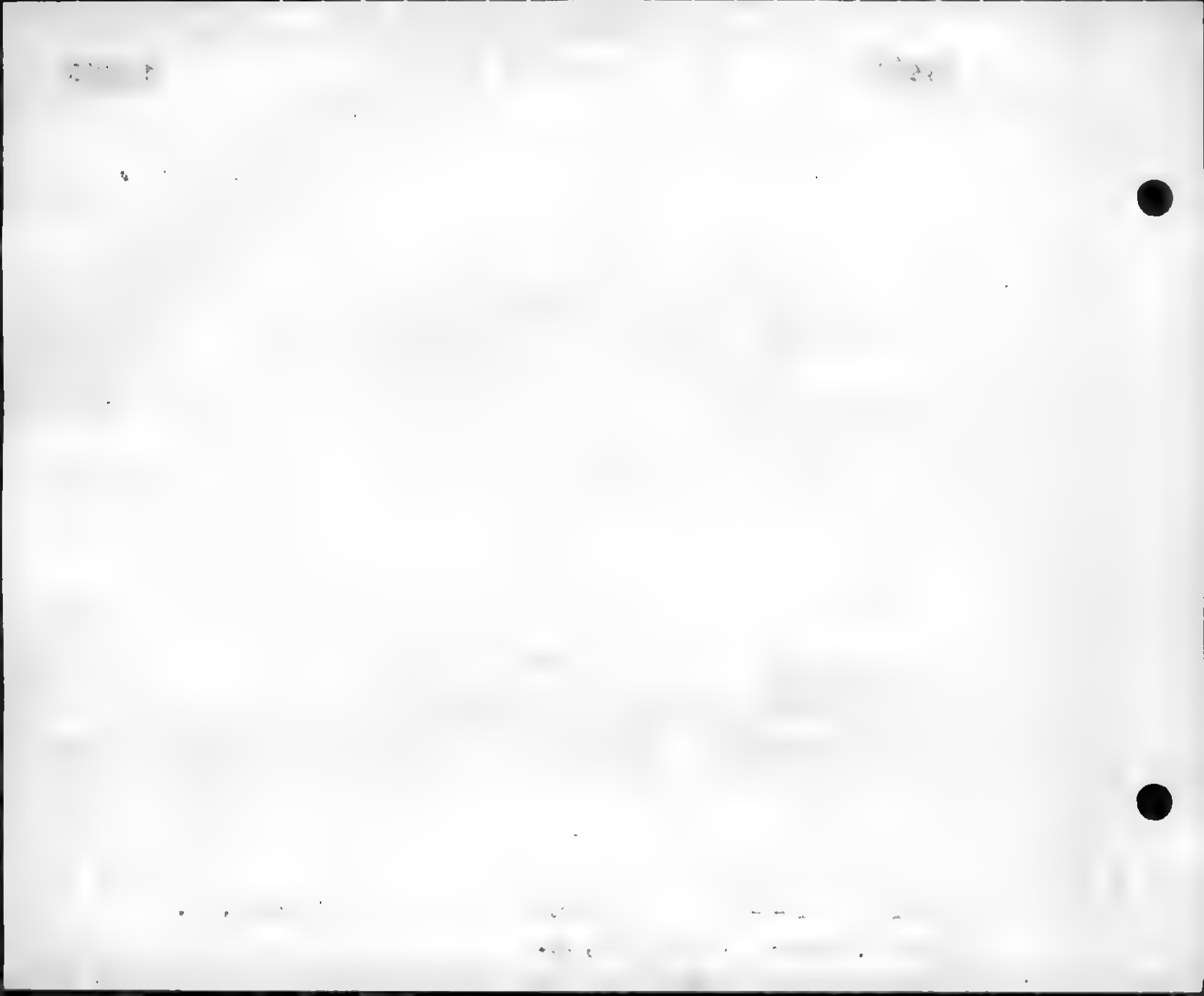
1 PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c. LENGTH OF STAY IN TB <u>36 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp of S.S. Md.</u>		d. STREET ADDRESS <u>14015 Layhill Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Frazier</u> Middle <u>Newton</u> Last <u>Montgomery, Jr</u>		4 DATE OF DEATH Month <u>10</u> - Day <u>2</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-30-66</u>
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u> Hours <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frazier Montgomery</u>		14. MOTHER'S MAIDEN NAME <u>Redman Elizabeth - 14015 Layhill Rd. - S.S., Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hematoma</u> <u>7600</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/1/66</u> , 19 <u>66</u> , to <u>10/2/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/1/66</u> , 19 <u>66</u> , and that death occurred at <u>8:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard J. Hollister</u>		22b. DATE SIGNED <u>10/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard J. Hollister</u>		22d. ADDRESS <u>14015 Layhill Rd Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-6-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dickerson</u>		23d. LOCATION (City or Town) (County) (State) <u>Dickerson, Md.</u>	
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 11 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

Cleared with Dr. Barber

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.



14423

CERTIFICATE OF DEATH

14423

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN Tb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Spencerville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital, Olney, Md.</b>				d. STREET ADDRESS <b>None</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Kenneth</b> Middle <b>Russell</b> Last <b>Moore</b>			4. DATE OF DEATH Month <b>10</b> Day <b>20</b> Year <b>19 66</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/21/08</b>	9. AGE (In years lost birthday) yrs. <b>58</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trash Disposal</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CIT. ZEN. OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Unknown Nathaniel Moore</b>			14. MOTHER'S MAIDEN NAME <b>Unknown Della Williams</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>214-14-8204</b>		17. INFORMANT <b>Family, Spencerville, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>In 40 Cardiac Infarction - Postoperative</b> DUE TO (b) <b>Atherosclerotic Occlusion - (P. Coronary Artery)</b> DUE TO (c) <b>Atherosclerosis - Coronary Arteries - Severe</b>					INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>hours</b> <b>-days</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension - mild, Essential</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (1) (this hospital) attended the deceased from <b>May 8</b> , 19 <b>66</b> to <b>Oct 17</b> , 19 <b>66</b> (or (1) we) last saw the deceased alive on <b>Oct 17</b> , 19 <b>66</b> , and that death occurred at <b>7:35 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>John R. Spencer</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>John R. Spencer</b>		22d. ADDRESS <b>15444 Columbia Rd., Burtonsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/23/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Burtonsville Mt. Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Dewitt Donaldson</b>		ADDRESS <b>3184 Albett Ave</b>		25. REC'D BY REGISTRAR DATE <b>OCT 25 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

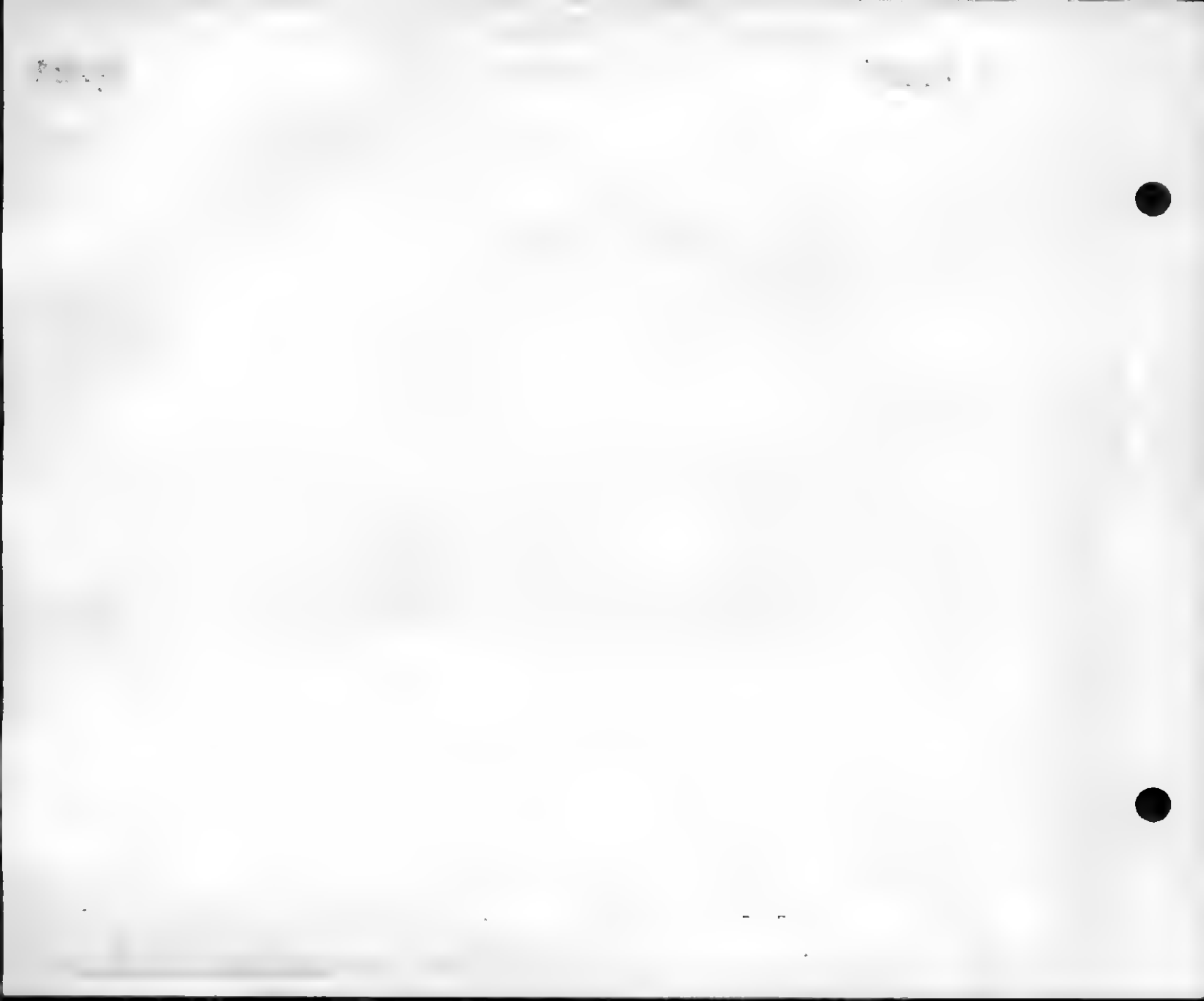
14424

CERTIFICATE OF DEATH

14424

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>				d. STREET ADDRESS <u>4810 Eastern Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NINA</u> Middle <u>A</u> Last <u>MORT</u>				4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-10-1894</u>	9. AGE (In years last birthday) <u>72 yrs</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ward Algate</u>				14. MOTHER'S MAIDEN NAME <u>Lois Danley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Betty Gray</u> Address <u>4810 Eastern Lane Suitland Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>1992</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Sigmoid and Bladder</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized ARTERIO SCLEROSIS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> , 19 <u>66</u> , to <u>10/25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/24</u> , 19 <u>66</u> , and that death occurred at <u>1242</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Raymond T. Benack</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/25/65</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>				22d. ADDRESS <u>4115 Colie Drive, Wheaton Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-29-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lauderdale Mem. Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Fort Lauderdale Florida</u>	
24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> Address <u>4308 Suitland Rd Suitland Maryland</u>				25a. REC'D BY REGISTRAR <u>DATE OCT 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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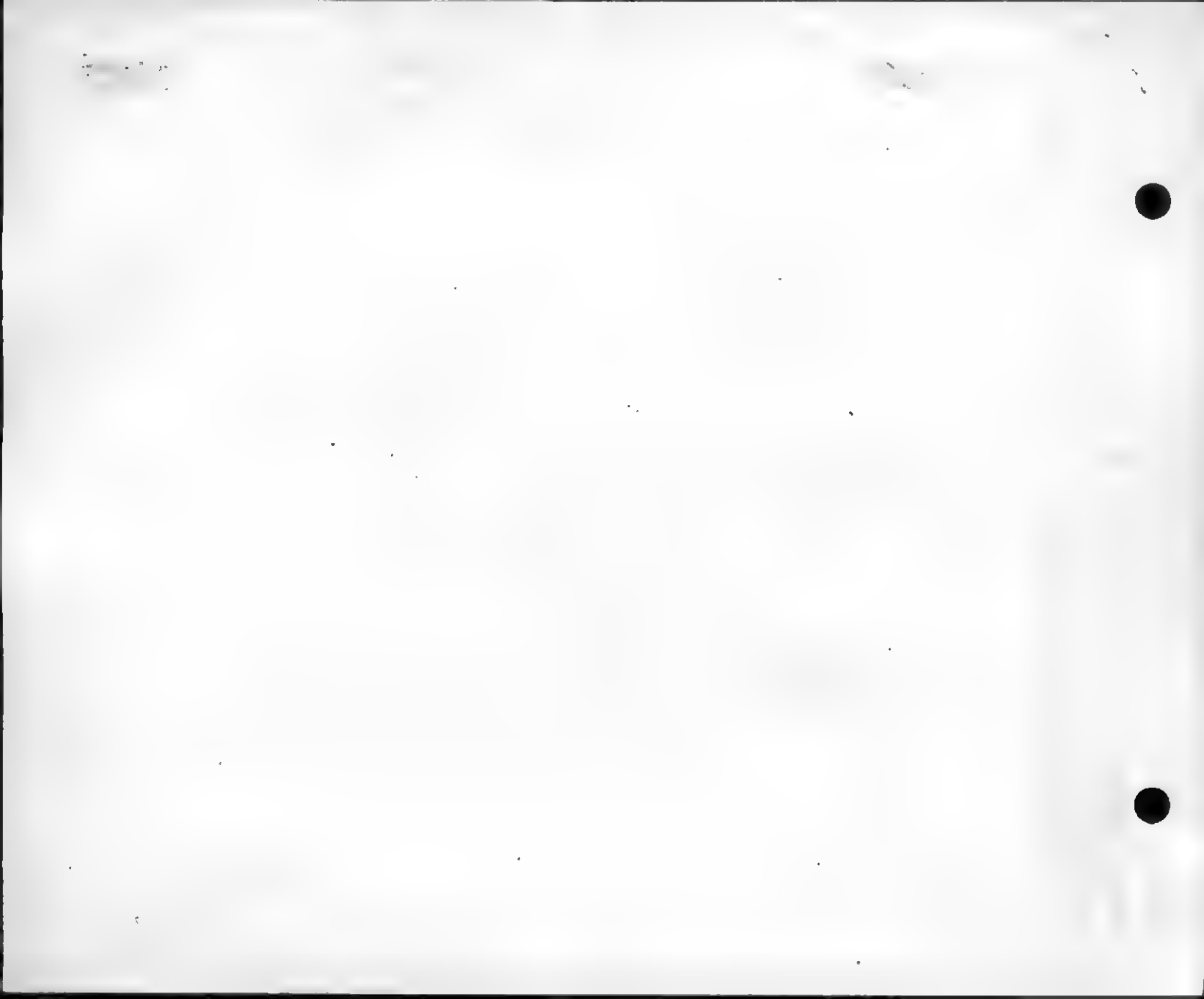
CERTIFICATE OF DEATH

14425

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in lb <u>13 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5822 Stone Oak Dr</u>	
3 NAME OF DECEASED (Type or print) First <u>Ross</u> Middle <u>A.</u> Last <u>Mossburg</u>		4 DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>1966</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-24-14</u>
9 AGE (In years last birthday) <u>51</u> yrs		10 IF UNDER 1 YEAR Months <u>11</u> Days <u>20</u> IF UNDER 24 HRS Hours <u></u> Min <u></u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schedule Maker</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Transit</u>	
12 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		13 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14 FATHER'S NAME <u>Charles W. Mossburg</u>		15 MOTHER'S MAIDEN NAME <u>Lelia E. Poole</u>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		17 SOCIAL SECURITY NO. <u>578-10-5072</u>	
18 INFORMANT <u>Betty R. Mossburg</u> Address <u>Same</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Rupture, esophageal varices</u> DUE TO (c) <u>Cirrhosis, liver</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Massive ascites, hypo proteinemia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>10-3-1966</u> to <u>10-13-1966</u> , that (I) (we) last saw the deceased alive on <u>10-13-1966</u> , and that death occurred at <u>5:34</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Linwood H. Johnson Jr.</u> M.D.		22b. DATE SIGNED <u>10-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>LINWOOD H. JOHNSON JR.</u>		22d. ADDRESS <u>4405 E-W Highway, Bz. Tharde, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-17-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Maryland</u>	
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 19 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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14426

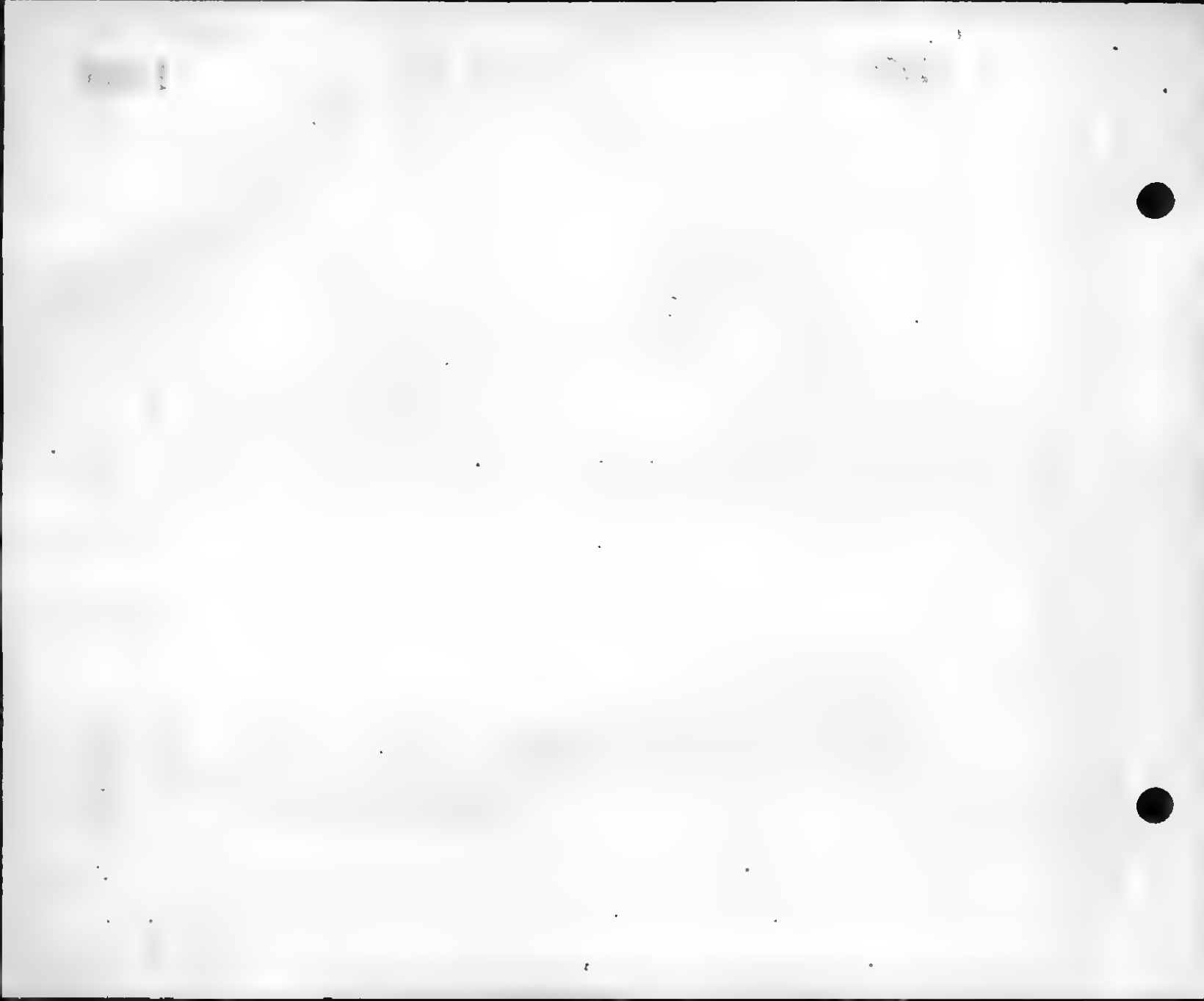
CERTIFICATE OF DEATH

14426

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>11 hrs. 35 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>4418 Ambler Drive</u>	
3 NAME OF DECEASED (Type or print) <u>Louis E. Mundy</u>		4 DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 <del>NEVER MARRIED</del> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/92</u>
9 AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR Months <u>8</u> Days <u>16</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from Gov.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>William Mundy</u>		14. MOTHER'S MAIDEN NAME <u>Mathilda Krebbs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>579-60-4176</u>	
17 INFORMANT <u>Daughter</u>		Address <u>Mrs. Ira Shoemaker</u> Same as Item 2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X</u> DUE TO <u>Cancer of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/1/65</u> to <u>10/31</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/31</u> , 19 <u>66</u> , and that death occurred at <u>725</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Curry M.D.</u>		22b. DATE SIGNED <u>11/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY</u>		22d. ADDRESS <u>10620 Georgia Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-4-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 7 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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96

VR A15 (4)  
20 M 1/66

(M)

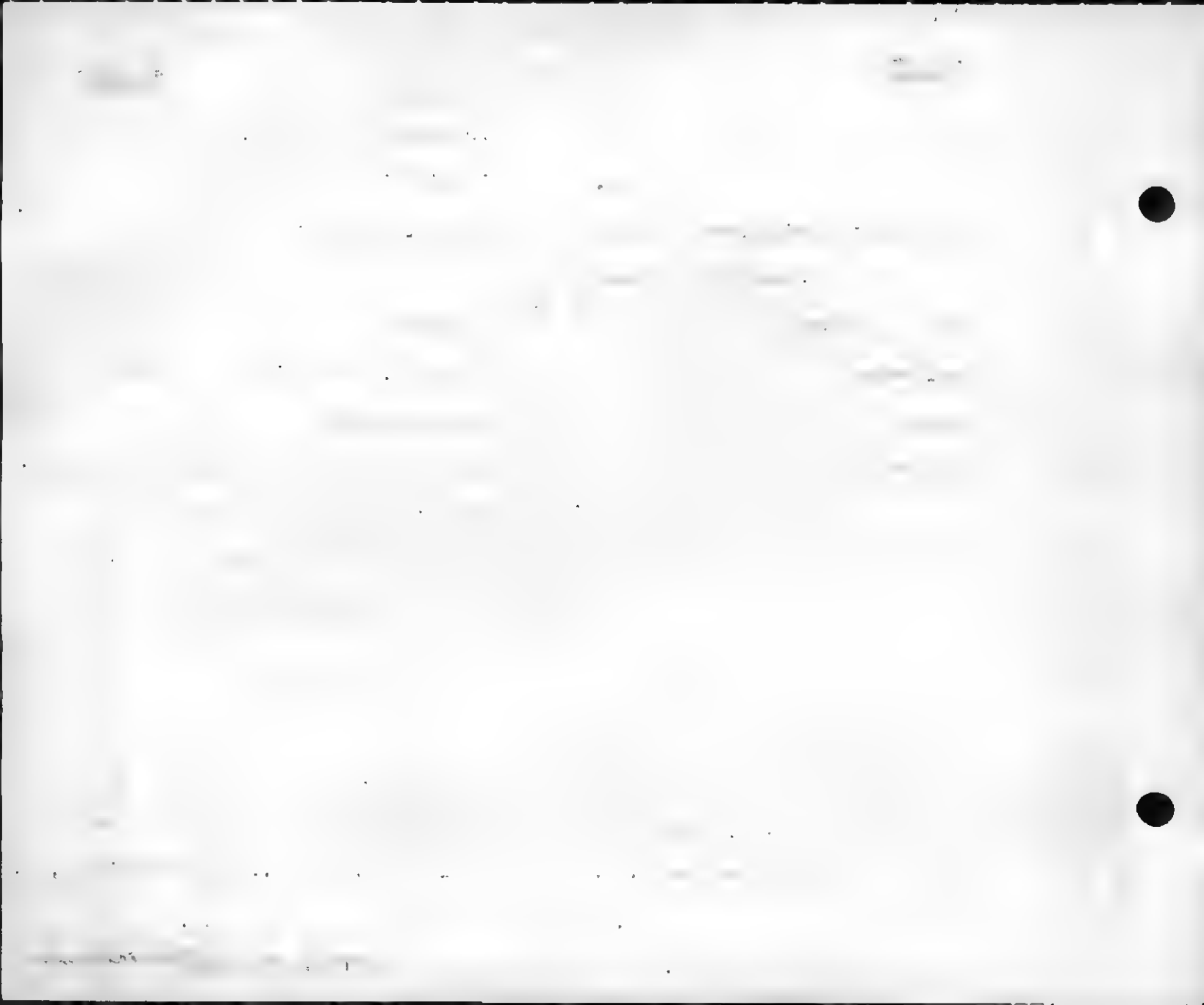
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14427

CERTIFICATE OF DEATH

14427

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY IN 1b <b>1 mo.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>		d. STREET ADDRESS <b>5717 Offutt Drive</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>John Francis Nassif</b>		4. DATE OF DEATH Month Day Year <b>10 - 23 - 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>5/15/1897</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool maker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Stamford, Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph</b>		14. MOTHER'S MAIDEN NAME <b>Mary Barbart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO.	
17 INFORMANT <b>Mrs. Ann Moreno 4900 O Street Hillside, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Cervix</b> DUE TO <b>with metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1</b> , 19 <b>65</b> to <b>Oct 23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Oct. 23</b> , 19 <b>66</b> , and that death occurred at <b>8:15</b> P.M., from causes and on the date stated above.			
22a. SIGNATURE <b>William Brainin</b>		22b. DATE SIGNED <b>10/23/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>William Brainin, M. D.</b>		22d. ADDRESS <b>6124 Central Ave., Capitol Heights, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/27/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OLIVET CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON D.C.</b>
24. FUNERAL DIRECTOR <b>WILHELM FEDERAL HOME ADDRESS</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 27 1966</b>	

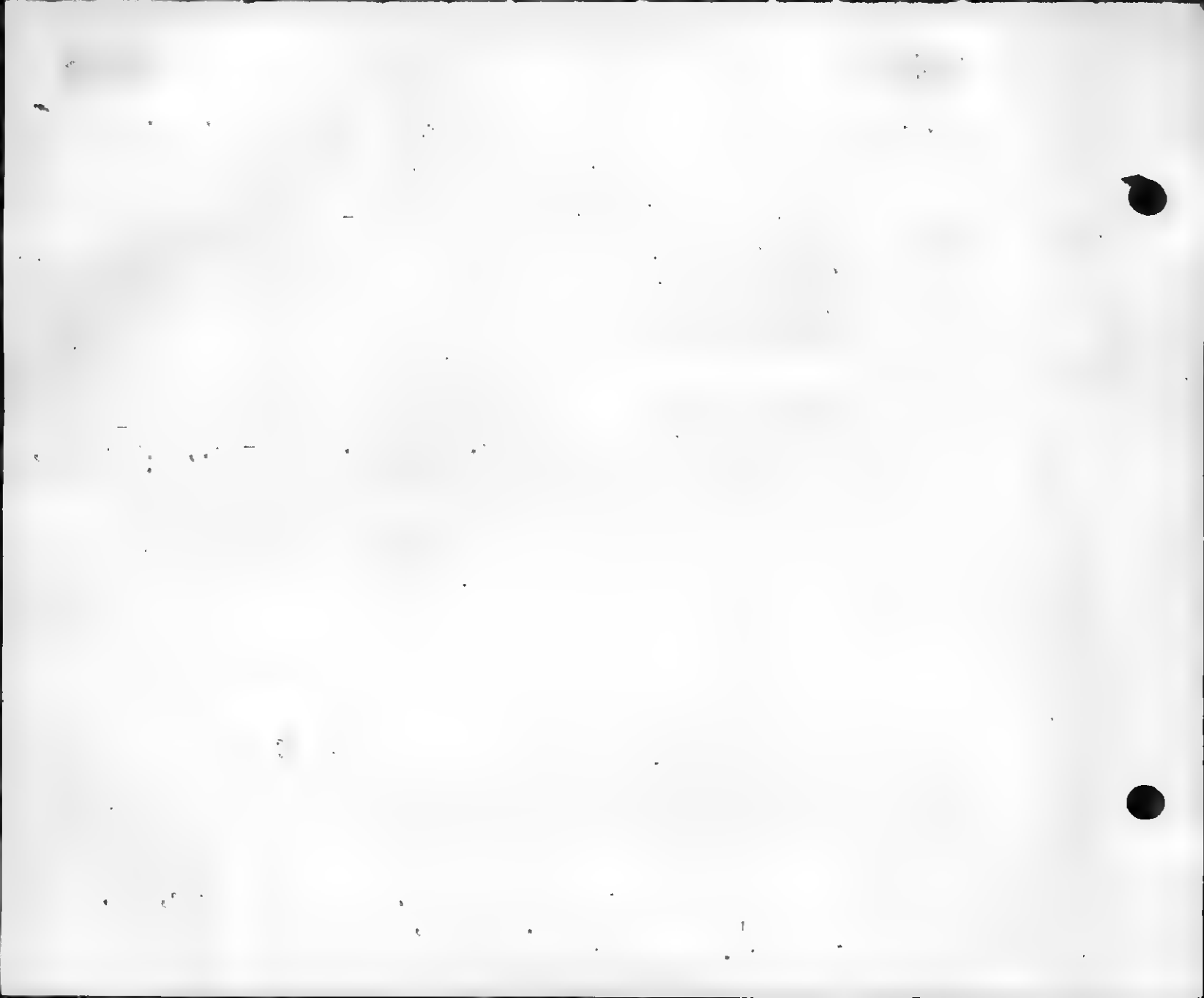


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14428 CERTIFICATE OF DEATH 14428

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>1 month, 9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home Fairland Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>FR. Geo.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> d. STREET ADDRESS <u>Route 2 - Box 117</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Albert BEYARD Neal</u>		4. DATE OF DEATH <u>10 - 16 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-1877</u> 9. AGE (in years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't Emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. OSCAR NEAL</u>		14. MOTHER'S MAIDEN NAME <u>Josephine BOSWELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-38-7140</u>	
17. INFORMANT <u>Mr. Oscar T. Neal - St. Mt. Rainier, Md.</u> Address <u>4104 - 31st</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia &amp; Cardiac failure</u> 7500 DUE TO (b) <u>Upper Respiratory Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>10-16</u> , 1966, that (I) (we) last saw the deceased alive on <u>9-27</u> 1966, and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edolo Pierandrea</u> M.D.		22b. DATE SIGNED <u>10-16-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/19/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE	
ADDRESS <u>Mt. Rainier, Maryland</u>		DATE <u>OCT 20 1966</u>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME  
SM 1/63

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERS BURG</u> d. STREET ADDRESS <u>Route 3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Philip</u> Middle <u>Noland</u> Last <u>Noland</u>				<b>4. DATE OF DEATH</b> Month <u>Oct</u> Day <u>1</u> Year <u>1966</u>							
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 13, 1914</u>		<b>9. AGE</b> (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>George Noland</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>NETTIE MACABEE</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes - 2nd Lt. - U.S. -</u>		<b>16. SOCIAL SECURITY NO.</b> <u>2nd Lt. - U.S. -</u>		<b>17. INFORMANT</b> <u>Anna Paris - Sister -</u> Address <u>SAME -</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonitis, probable</u> <u>5271</u> DUE TO (b) <u>viral origin, generalized.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Emphysema</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>Belden R. Reap</u> M.D. <b>EXAMINER'S NAME</b> (Type) <u>BELDEN R. REAP M.D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>Wheeler</u>				<b>DATE SIGNED</b> <u>Oct. 1, 1966</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>10/6/66</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Arlington VA.</u>			
<b>23. FUNERAL DIRECTOR</b> <u>Robert L. Snodden</u>				<b>24a. REC'D BY REGISTRAR</b> <u>Rockwell</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>John Charles J...</u>		<b>DATE</b> <u>OCT 6 1966</u>			



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

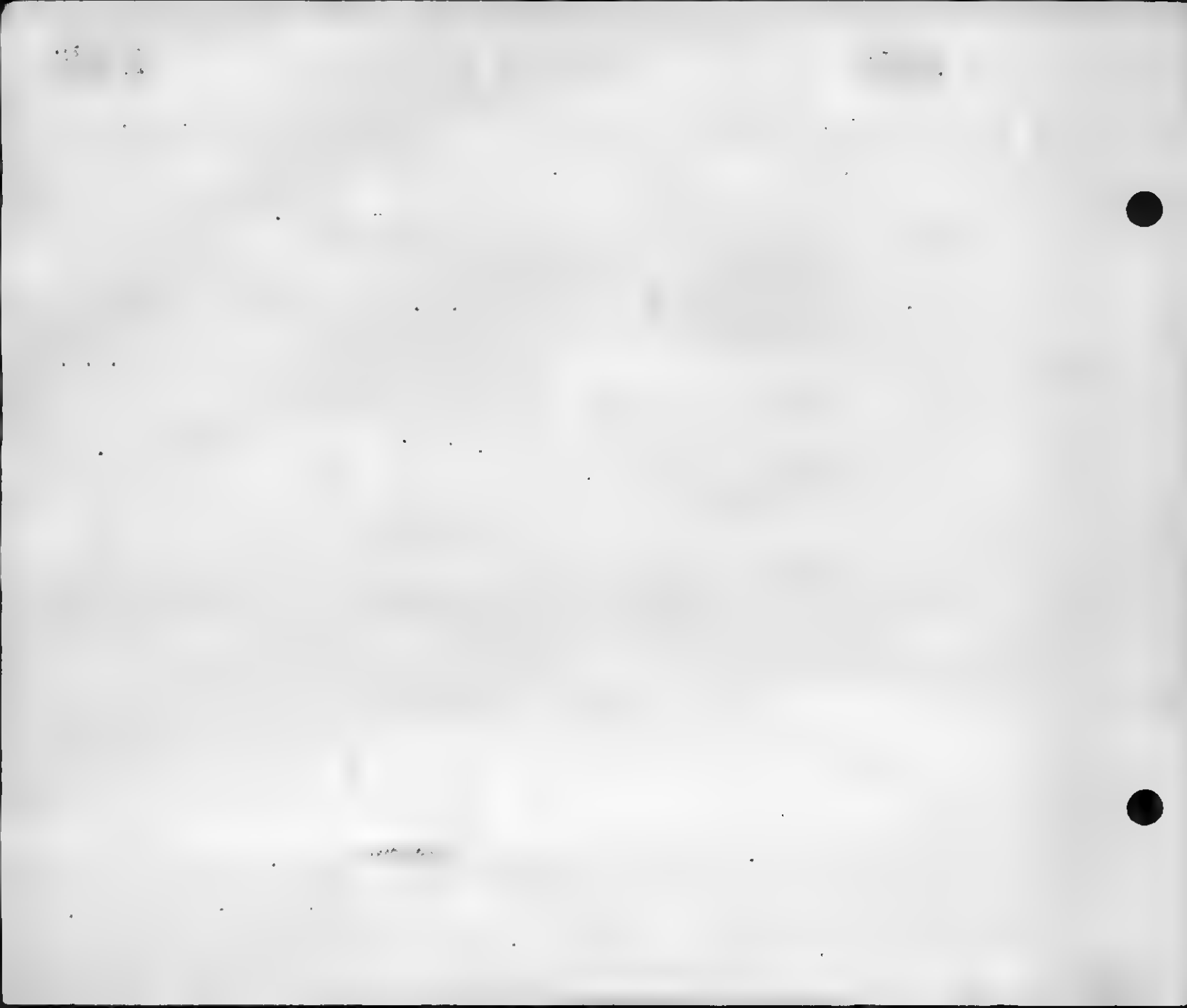
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14430

14430

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Beallsville</b> c. LENGTH OF STAY IN b. <b>6 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Ranier</b> d. STREET ADDRESS <b>4107 - 28th St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CORA Ellen NORRIS</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>8</b> Year <b>1966</b>		5. SEX <b>Fem.</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 9. 1880</b>		9. AGE (In years last birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Bowman</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Darby</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-48-9516c.</b>		17. INFORMANT <b>W. Norris</b>		Address <b>Beallsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYDROSTATIC PNEUMONIA</b> DUE TO (b) <b>ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Beallsville</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12 April 1965</b> to <b>Oct 8 1966</b> that (I) (we) last saw the deceased alive on <b>Oct 8 1966</b> and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>John G. Fawcett</b>				M.D. <b>John G. Fawcett</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>John G. Fawcett</b>				22d. ADDRESS <b>Boyd's, Mary, and.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		23d. LOCATION (City, town or county) <b>Beallsville</b>		(State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>				ADDRESS <b>Barnesville, Md</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Phyllis Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

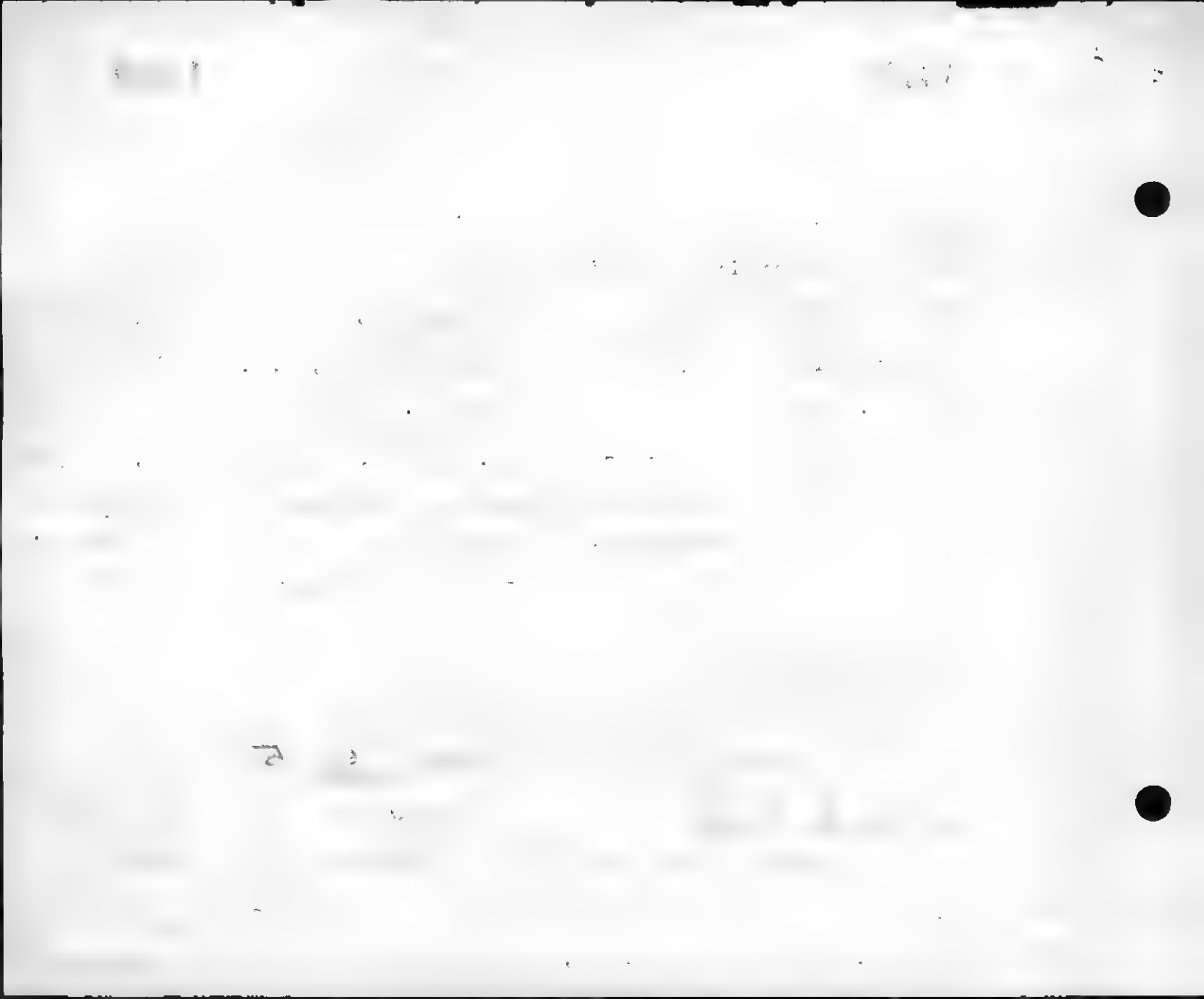
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14431

CERTIFICATE OF DEATH

14431

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Westchester</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poolesville</b>		c LENGTH OF STAY IN 1b <b>? 2 months</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Reddick Road - Red Oak Farms</b>		d. STREET ADDRESS <b>Bronxville, New York</b>	
3 NAME OF DECEASED (Type or print) First <b>Geraldine</b> Middle <b>Carlie</b> Last <b>OBERHAMMER</b>		4 DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>19 66</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>September 15, 1910</b>
9 AGE (n years last birthday) yrs <b>56</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receptionist</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11 BIRTHPLACE (County & State, or foreign country) <b>New York City, N. Y.</b>	
12 CIT ZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Samuel P. Heap</b>	
14. MOTHER'S MAIDEN NAME <b>Edna C. Schlater</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> NO	
16 SOCIAL SECURITY NO <b>061-10-3650</b>		17 INFORMANT <b>Daughter</b> Address <b>Mrs. Sandra O. Karn, Poolesville, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia, Bictoral</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma</b> DUE TO (c) <b>Carcinoma of Right Breast</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>3 months</b> <b>16 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>17 Aug., 1966</b> , to <b>5 Oct., 1966</b> , that (I) <del>(two)</del> last saw the deceased alive on <b>4 Oct</b> 1966, and that death occurred at <b>6:30 P.M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>Gordon M. Smith</b>		22b. DATE SIGNED <b>5 Oct 66</b>	
22c PHYSICIAN'S NAME (Type) <b>Gordon M. Smith, M.D.</b>		22d. ADDRESS <b>Barnesville, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>	23b DATE THEREOF <b>10/5/1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Beachwood Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>New Rochelle New York</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		25a REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 7 1966</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14432

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14432

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5604 Pollard Rd.</b>		d. STREET ADDRESS <b>5604 Pollard Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>E.</b> Last <b>O'CONNELL, JR.</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>22,</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 19, 1915</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR <b>9</b> Months <b>3</b> Days <b>3</b> Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ass't Secy. Home Building Assoc.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Frank E. O'Connell, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Gogan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>579-44-2752</b>	
17. INFORMANT <b>father</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus, nephrosis of liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>few hours</b> <b>years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 2, 1949</b> to <b>10-22-1966</b> , that (I) (we) last saw the deceased alive on <b>10-22-1966</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>C P Ryland</b>		22b. DATE SIGNED <b>10-22-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>C P RYLAND</b>		22d. ADDRESS <b>4400-49 St. NW. Washington DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-26-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Richmond, Virginia</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 26 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

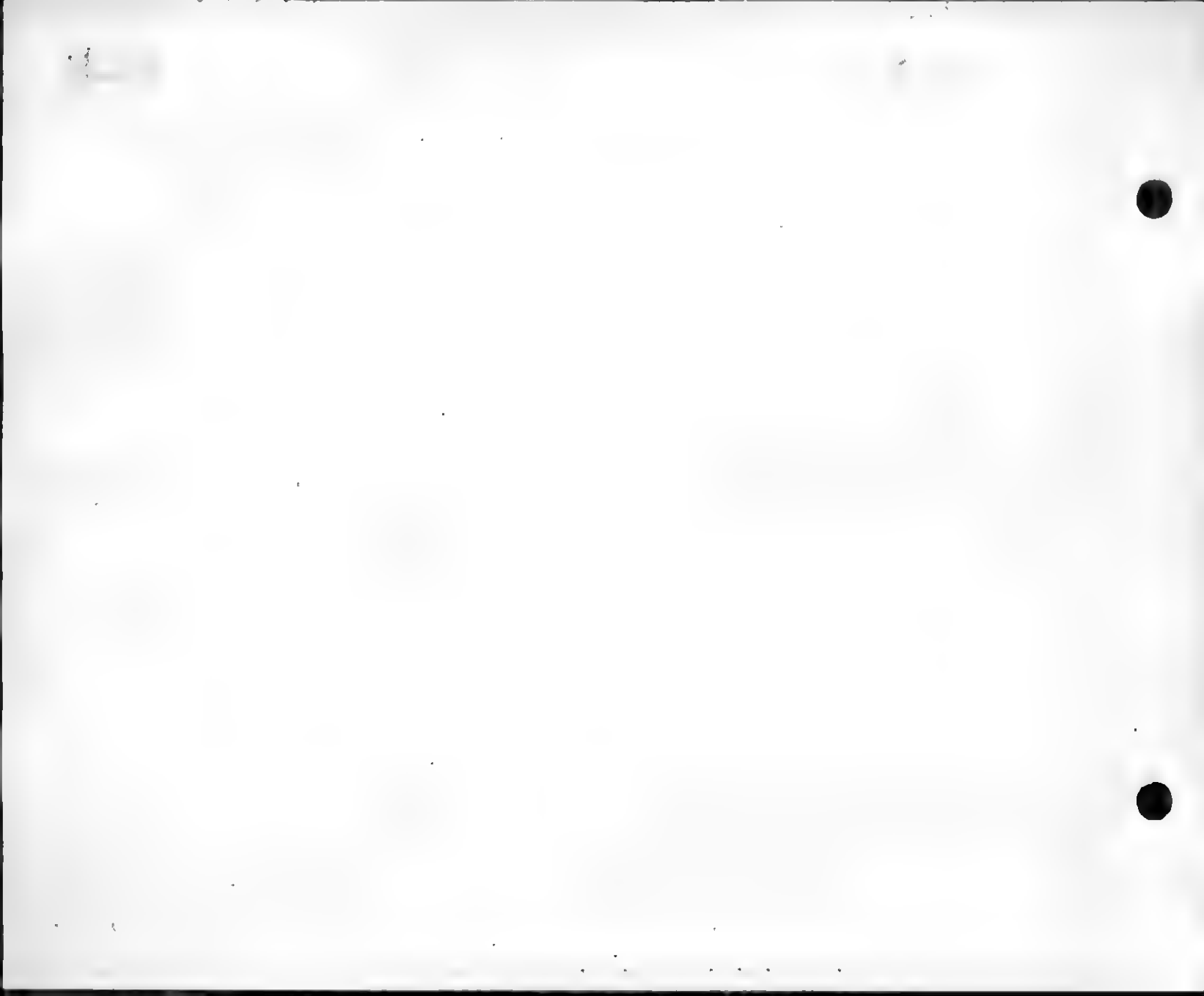
**14433**

**CERTIFICATE OF DEATH**

**14433**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4403 Franklin St.</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>T.</u> Middle <u>Oest</u> Last <u>Oest</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-10</u>
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Credit Manager</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Suburban Trust Co.</u>	
13. BIRTHPLACE (County & State or foreign country) <u>NEW JERSEY</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. FATHER'S NAME <u>William H. Oest</u>		16. MOTHER'S MAIDEN NAME <u>Catherine Wehmann</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO <u>578-24-1873</u>	
19. INFORMANT <u>Wife - Dorothy C. Oest</u>		Address <u>Same</u>	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4.5 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <u>Oct. 6</u> , 19 <u>66</u> , to <u>Oct. 8</u> , 19 <u>66</u> that (we) last saw the deceased alive on <u>Oct. 8</u> , 19 <u>66</u> , and that death occurred at <u>2:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John R. Green MD</u>		22b. DATE SIGNED <u>10-8-66</u>	
22c. PHYSICIAN'S NAME (Type) _____		22d. ADDRESS <u>916 14th St. N.W. Wash. DC.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-12-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery/ Silver Spring, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 13 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

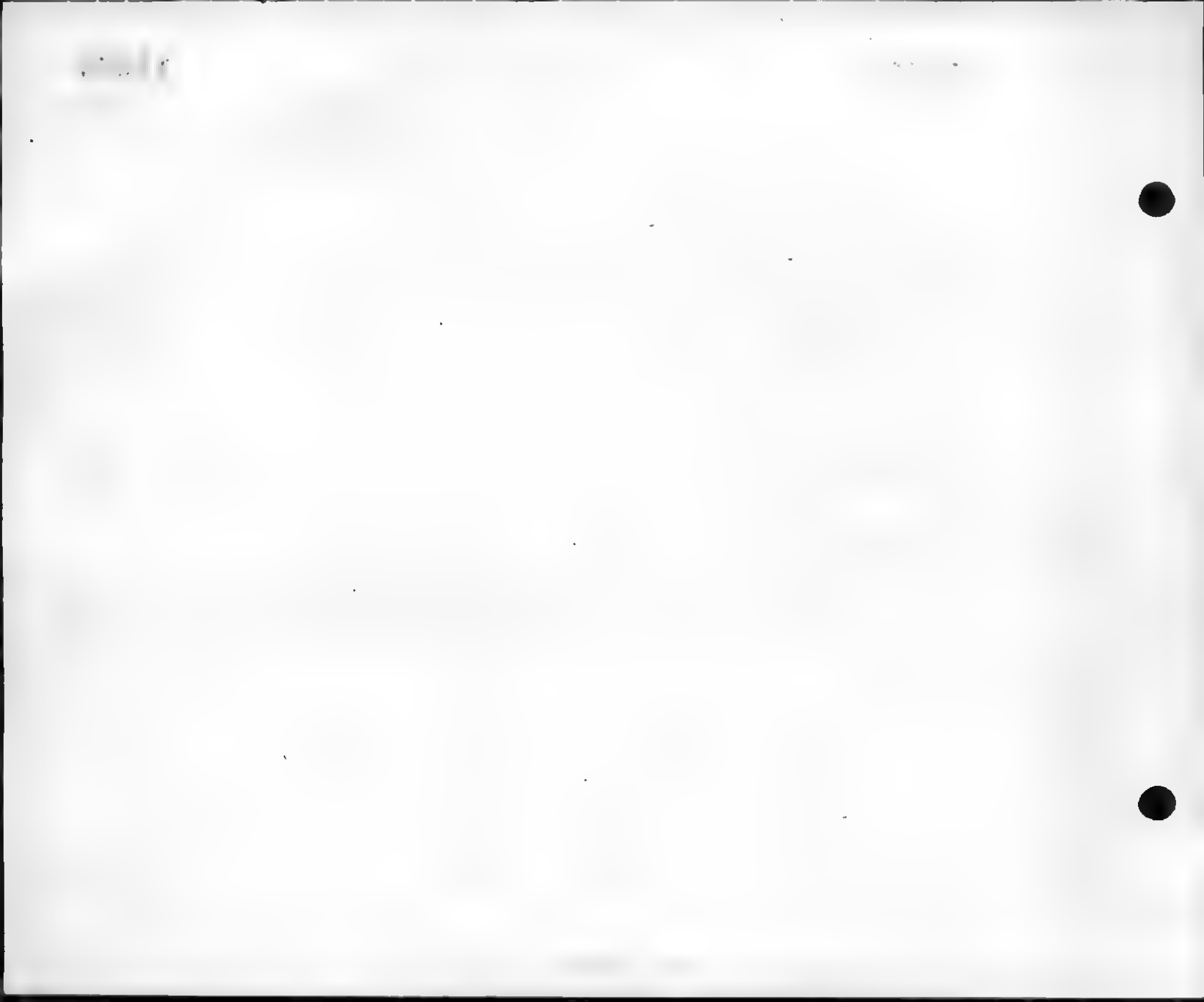
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14434

CERTIFICATE OF DEATH

14434

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>17 hr 45 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>				d. STREET ADDRESS <u>2218 Charleston Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>MAY</u> Last <u>OSSENFORT</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>1966</u>			
5. SEX <u>FE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/90</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES MORRISON</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE IRVINE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>HOSPITAL RECORDS</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic cardio-vascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>unknown</u> <u>unknown</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 25, 1960</u> , to <u>Oct. 30, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 30</u> 1966, and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Eino Magi</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-31-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>				22d. ADDRESS <u>831 University Blvd. E. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 2, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenfield Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Hempstead, L.I., New York</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		ADDRESS <u>254 Carroll St. N.W. Washington, D.C.</u>		25a. REC'D BY REGISTRAR OATE <u>NOV 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

14435

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

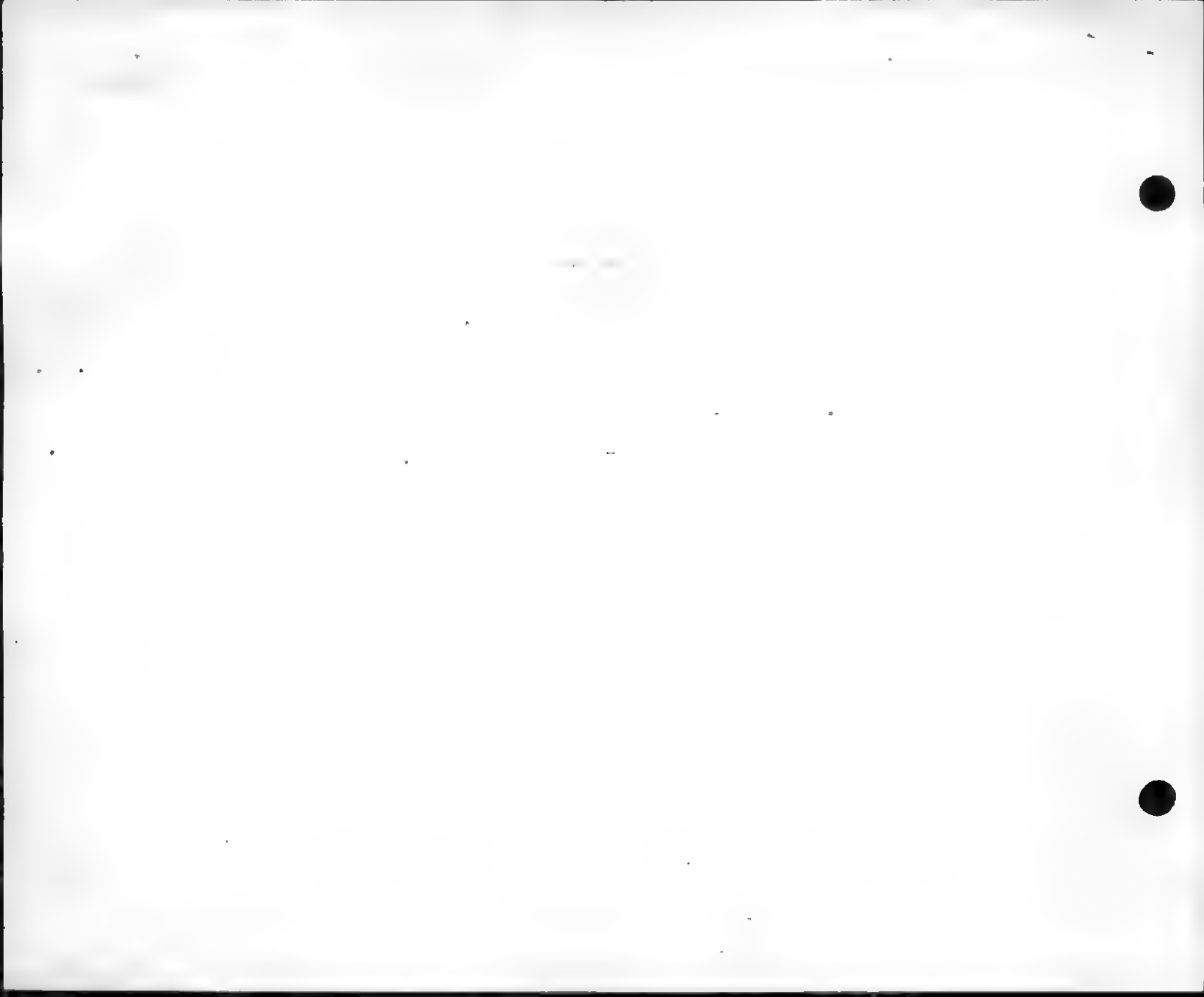
14435

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>4022 Jeffrey Street</b>	
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>Richard</b> Middle <b>PELLEU</b> Last		4. DATE OF DEATH Month <b>6</b> , Day <b>October</b> , Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1928</b>
9. AGE (in years last birthday) <b>37</b> yrs		10. UNDER 1 YEAR Months <b>10</b> Days <b>13</b>	11. F UNDER 24 HRS Hours <b>10</b> Min <b>13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Agency</b>	
11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>George B. Pelleu, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Lucille Merryman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>Yes</b> <b>Korean</b>		16. SOCIAL SECURITY NO <b>212-2442517</b>	
17. INFORMANT <b>Wife</b> <b>Phyllis L. Pelleu</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO (b) <b>Hypertension, Essential</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Roap</b> M.D.		22. DATE SIGNED <b>OCT. 6, 1966</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. ROAP, M.D.</b>		Address (Street, City, Town or County) <b>Wheaton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-10-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. RECD BY REGISTRAR <b>OCT 10 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATE



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

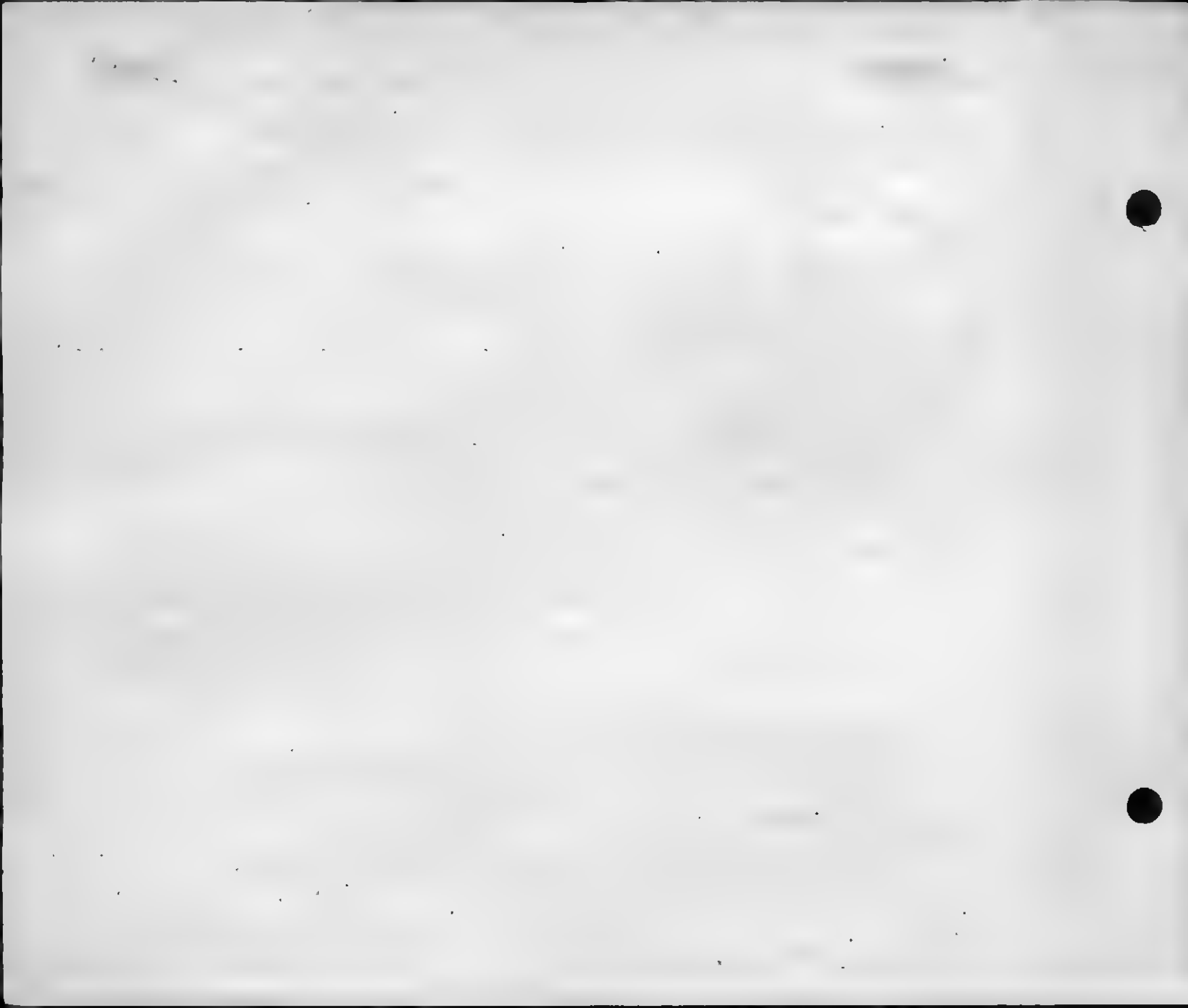
## CERTIFICATE OF DEATH

14436

14436

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13120 Beaver Terrace</u>				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>13120 Beaver Terrace</u>			
3. NAME OF DECEASED (Type or print) <u>Katherine Frances Pendergast</u>				4. DATE OF DEATH <u>10 8 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 23, 1880</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>United Ice &amp; Coal Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harrisburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Pendergast</u>				14. MOTHER'S MAIDEN NAME <u>Susanna Donnelly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>195-07-9480</u>		17. INFORMANT <u>Paul A. Breen</u>		Address <u>13120 Beaver Terrace Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Old age</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Years</u> <u>Years</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1964</u> to <u>Oct 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 8 1966</u> , and that death occurred at <u>12:4</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard P. Delaney</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 8, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard P. Delaney</u>				22d. ADDRESS <u>4323 Harvard Street, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>Oct 11, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Harrisburg, Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Carter</u> ADDRESS <u>8434 Georgia Avenue</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Warner C. Humphrey, Inc. <u>Silver Spring, Md.</u>				DATE <u>OCT 13 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

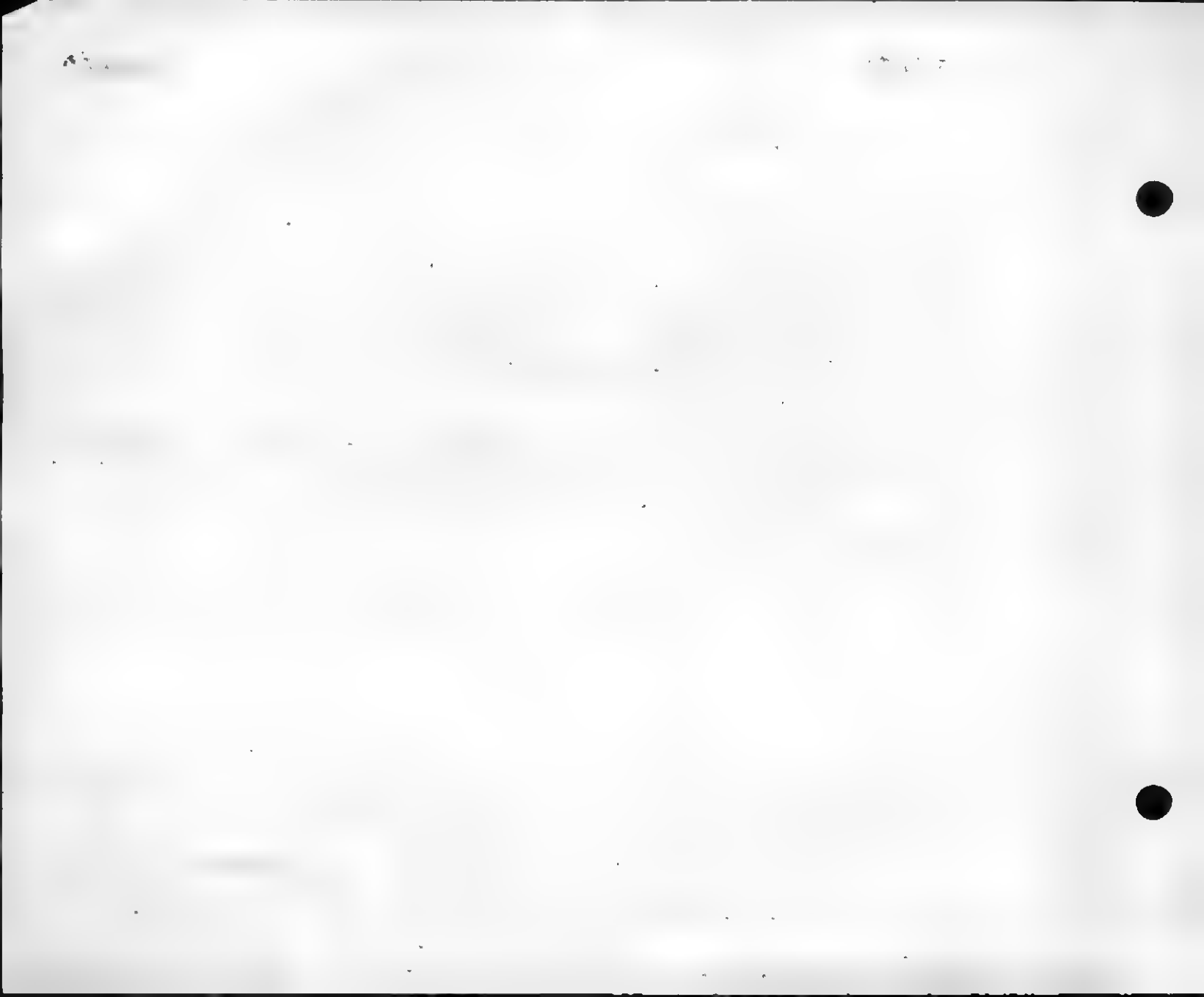
**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

14437

14437

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>13503 KEATING ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RALPH CLIFTON PHILLIPS</b>				4. DATE OF DEATH Month <b>10-</b> Day <b>20</b> Year <b>19 66</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-94</b>		9. AGE (In years last birthday) <b>72</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER, RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bldg. Construction</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EDWARD PHILLIPS</b>				14. MOTHER'S MAIDEN NAME <b>ADA SOUDER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>214-03-8646</b>		17. INFORMANT <b>Mrs. Miriam A. Phillips</b> Address <b>13503 Keating St. Rockville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10/14</b> , 19 <b>66</b> , to <b>10/20</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10/20</b> , 19 <b>66</b> , and that death occurred at <b>4:08 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>A. D. Bonifant</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M. D.</b>				22d. ADDRESS <b>Sandy Springs, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 24, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>			
24. FUNERAL DIRECTOR <b>Clark E. Wisor</b> <b>Warner E. Humphrey, Inc.</b>		ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14438

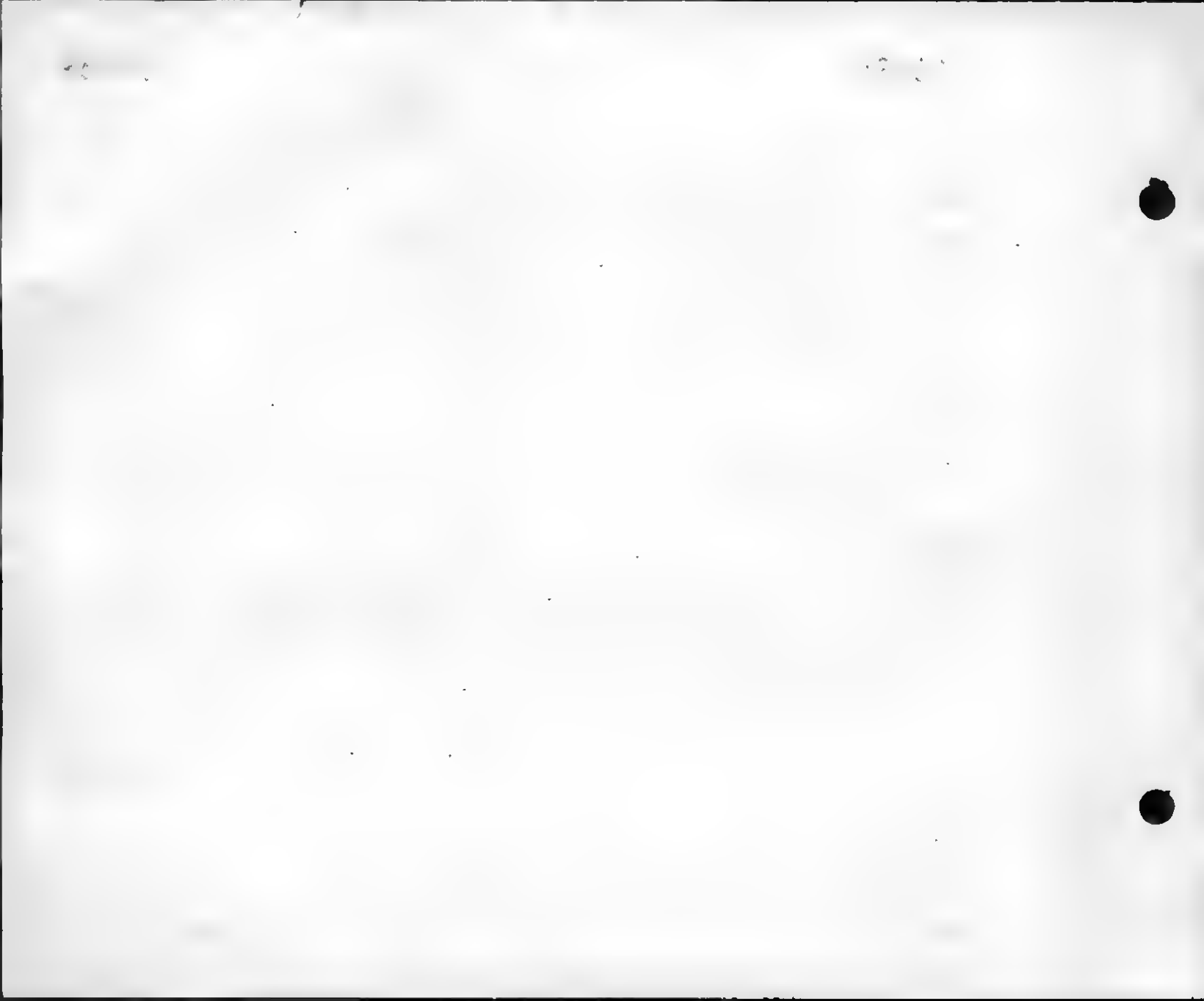
## CERTIFICATE OF DEATH

14438

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and completely filled in by the funeral director. After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Henry W. Jaeger, Notified & approved release 10/10/66

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTG.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
c. LENGTH OF STAY IN 1b <b>11 days</b>		d. STREET ADDRESS <b>9105 WALDEN RD.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM + HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GUSSIE ANITA PIPER</b>		4. DATE OF DEATH Month Day Year <b>10 - 10 - 1966</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-13-86</b>
9. AGE (In years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>VON POPER</b>		14. MOTHER'S MAIDEN NAME <b>LENA KELLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>-</b>	
17. INFORMANT <b>-</b>		Address <b>-</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary insufficiency</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) <b>Fracture, pathological, left femoral shaft</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized carcinomatosis from breast</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Pt fell at home</b>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	
20f. (City or town) <b>Silver Spring</b> (County) <b>Ind.</b> (State)		21. I certify that (I) (this hospital) attended the deceased from <b>9-29</b> , 19 <b>66</b> to <b>10-10</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10-10</b> , 19 <b>66</b> , and that death occurred at <b>6:15</b> M, from causes and on the date stated above.	
22a. SIGNATURE <b>Henry W. Jaeger MD</b>		22b. DATE SIGNED <b>10-11-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry W. Jaeger</b>		22d. ADDRESS <b>1015 Spring St, Silver Spring Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 13, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or town) <b>Arlington</b> (County) <b>Virginia</b> (State)	
24. FUNERAL DIRECTOR <b>Arthur Walters, 227 Carroll Ave. W. CC</b>		25a. REC'D BY REGISTRAR <b>Charles J.</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>OCT 13 1966</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

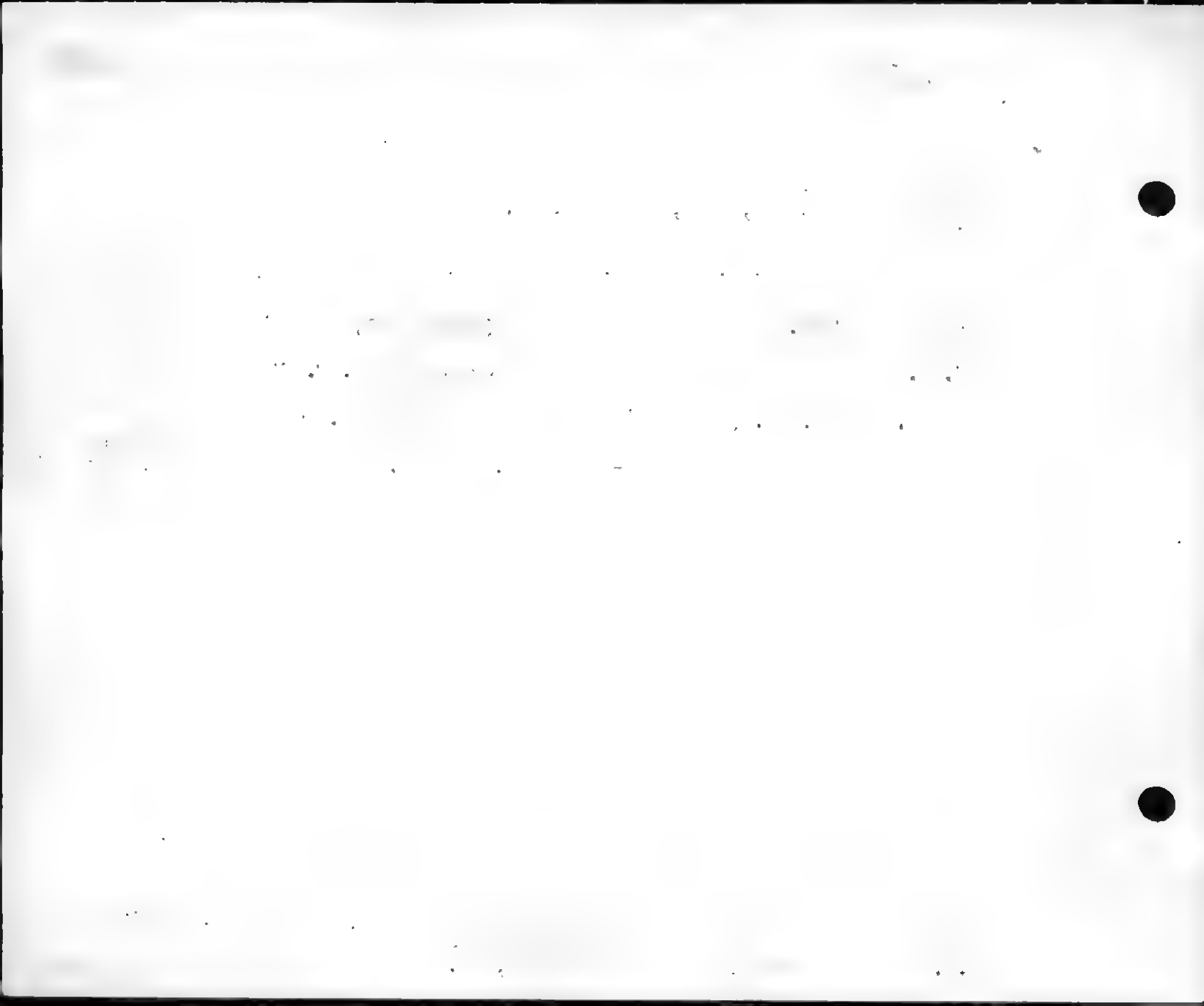
14439

14439

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>MONTGOMERY</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c LENGTH OF STAY IN 1b <b>4 1/2</b>			
d NAME OF DECEASED OR INSTITUTION (If not named, give street address) <b>Naval Medical School, NMHC, Bethesda, Md. Building #144</b>				e STREET ADDRESS <b>603 Boston Avenue</b>			
3 NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Bruce</b> Last <b>PITZER</b>				4 DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1966</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cauc.</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>13 April 1917</b>	9 AGE (In years last birthday) <b>49 yrs</b>	10 UNDER 1 YEAR Months <b>49</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	11 UNDER 24 HRS Hours <b>0</b> Min <b>0</b>	12 CITIZEN OF WHAT COUNTRY? <b>USA</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>				10b KIND OF BUSINESS OR INDUSTRY <b>Gerrardstown, W. Virginia</b>			
13 FATHER'S NAME <b>Harry M. Pitzer, Sr. (DECEASED)</b>				14 MOTHER'S MAIDEN NAME <b>Margaret M. Buchanan</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>				16 SOCIAL SECURITY NO <b>579-18-5871</b>			
17 INFORMANT <b>(Wife)</b>				18 ADDRESS <b>603 Boston Avenue Takoma Park, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gun Shot - Wound of Brain</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c) DUE TO DUE TO DUE TO							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Shot - self in head with 38 cal. pistol</b>			
20c TIME OF INJURY Month, Day Year <b>4:45 pm 10 29 1966</b>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc) <b>Home</b>	
20f (City or town) <b>Bethesda</b>				20g (County) <b>Montgomery</b>		20h (State) <b>Md</b>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John B. Ball</b>				22. DATE SIGNED <b>10/30/66</b>			
EXAMINER'S NAME (Type) <b>JOHN B. BALL</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <b>10/30/66</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>11/3/1966</b>		23c NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24 FUNERAL DIRECTOR <b>W.W. Chambers Funeral Home</b>				25a REC'D BY REGISTRAR <b>NOV 2 1966</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14440

## CERTIFICATE OF DEATH

14440

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN TB <b>7 hrs. 10 min.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>7 Sextant Green, S.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>POWELL</b>		4. DATE OF DEATH Month <b>10</b> - Day <b>23</b> - Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 23, 1966</b>
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John J. Powell</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Cromwell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Washington</b>		Address <b>D.C.</b> <b>Mr. John J. Powell, 7 Sextant Green, S.W.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity, Massive pulmonary atelectasis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from <b>Oct. 23</b> , 19 <b>66</b> , to <b>Oct. 23</b> , 19 <b>66</b> that (x) (we) last saw the deceased alive on <b>Oct. 23</b> , 19 <b>66</b> , and that death occurred at <b>7:10 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>T. E. Kelly</b>		22b. DATE SIGNED <b>25 October 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>T. E. Kelly, M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/26/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b> ADDRESS <b>1400 Chapin Street, N.W., Washington, D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 26 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Chambers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10-1

11/10/1



FOR STATE  
HEALTH DEPT.

14441

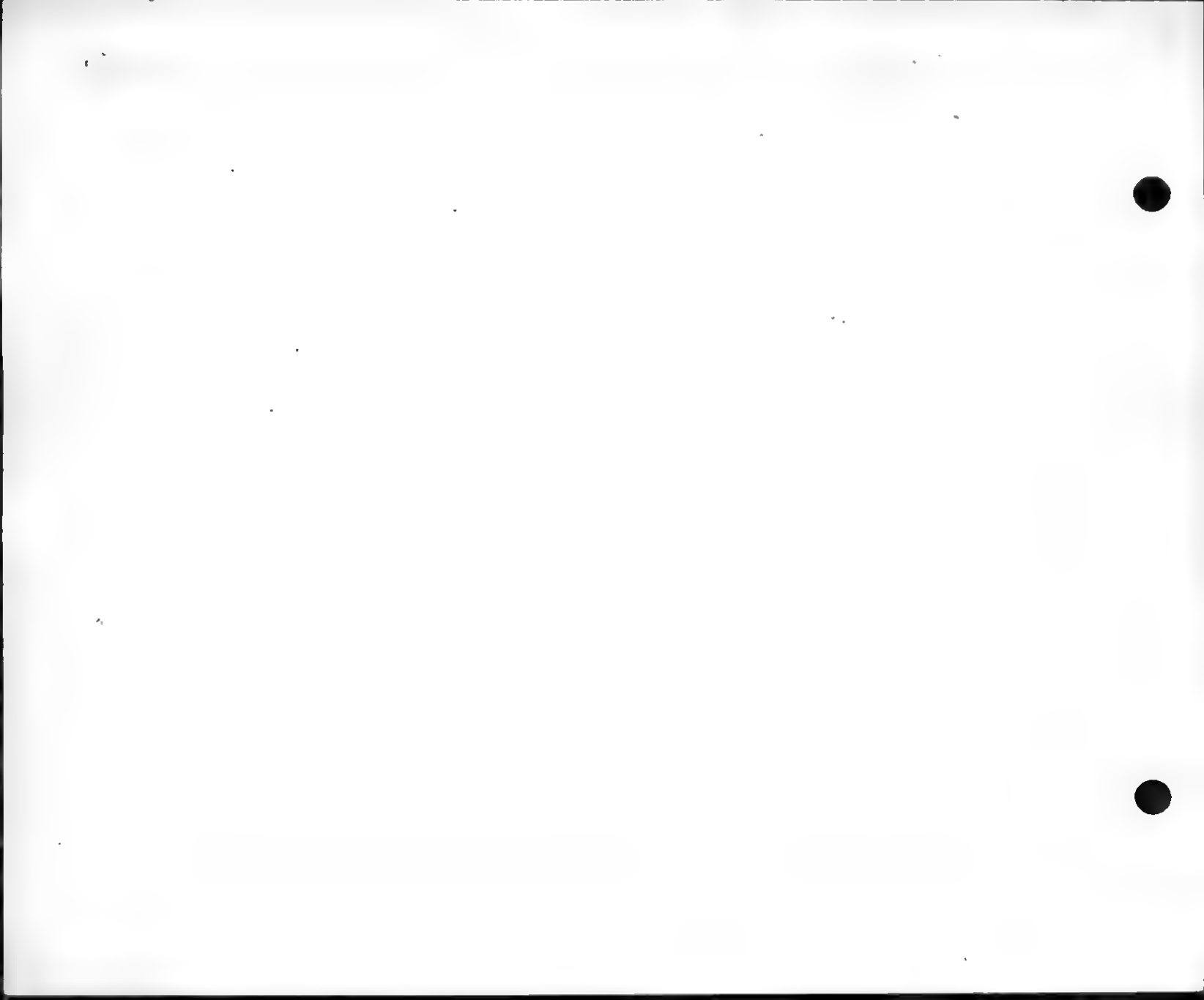
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14441

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not tuition. Residence before admission) <i>Maryland Prince George's County</i>	
a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>7 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>WASH. SAN. &amp; HOSP.</i>		d. STREET ADDRESS <i>801 Sligo Creek Pkwy</i>	
3. NAME OF DECEASED (Type or print) First <i>HELEN</i> Middle <i>JEAN</i> Last <i>PRAY</i>		4. DATE OF DEATH Month <i>OCT.</i> Day <i>9</i> Year <i>1966</i>	
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-21-43</i>
9. AGE (In years last birthday) yrs. <i>23</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Mins. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Ross</i>		14. MOTHER'S MAIDEN NAME <i>Mary Boyd</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Mary Boyd Ross</i>		18. ADDRESS <i>6935 Maple St. N.W. D.C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia due to Chronic Renal Disease</i> <i>445X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <i>Hypertensive cardiovascular disease</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i> EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		22. DATE SIGNED <i>Oct. 10, 1966</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>10-14-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	23d. LOCATION (City or Town) (County) (State) <i>Fort Myer Va.</i>
24. FUNERAL DIRECTOR <i>James J. Jenkins</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 17 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14442

14442

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>2 months - 13 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KENSINGTON GARDENS SANITARIUM</b>		e. STREET ADDRESS <b>12716 Epping Terrace</b>	
3 NAME OF DECEASED (Type or print) <b>William Richard PREECE SR.</b>		4 DATE OF DEATH <b>Oct. 7, 1966</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>	
11. BIRTHPLACE (County & State or foreign country) <b>ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elam PREECE</b>		14. MOTHER'S MAIDEN NAME <b>ERMA L. ROBERTS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>288-20-1886</b>	
17. INFORMANT <b>William R. PREECE JR.</b>		Address <b>12716 Epping Terrace, Wheaton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arterio sclerotic cerebral vessels</b> DUE TO <b>dissecting</b> (b) <b>dissecting</b> DUE TO <b>generalized arterio sclerosis</b> (c) <b>generalized arterio sclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS A JYOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/7, 1966</b> , to <b>10/7, 1966</b> , that (I) (we) last saw the deceased alive on <b>10/7, 1966</b> , and that death occurred at <b>LA M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>W. F. Kreuzburg</b>		22b. DATE SIGNED <b>10/7/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. F. Kreuzburg</b>		22d. ADDRESS <b>7652 16th Ave W, Oak Ridge, TN</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>October 9, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Niles, Ohio</b>
24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Rumphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 10 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14443 CERTIFICATE OF DEATH 14443

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D. of C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Nursing</u>		d. STREET ADDRESS <u>1809 - 26th Street, N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>THEODORA</u> Middle <u>C.</u> Last <u>PRESTON</u>		4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 27, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert Preston</u>		14. MOTHER'S MAIDEN NAME <u>Arlene McFarlane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-09-7309</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral vascular disease</u> 334X DUE TO (b) <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1964</u> to <u>Oct 4, 1966</u> , that (II) (we) last saw the deceased alive on <u>Oct 4, 1966</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>10/11/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>H F Kreuzburg</u>		22d. ADDRESS <u>2852 16th St NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Oct. 12, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	23d. LOCATION (City, town or county) (State) <u>Prince Georges County Md.</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
ADDRESS <u>254 Carroll St. N.W. Washington, D.C. 20001</u>		DATE <u>OCT 13 1966</u>	

1444

1444

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>25 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FAIRLAND NRSNG HOME 2101 FAIRLAND RD</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>XXXXXXXXXXXX</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>XXXXXXXXXXXX Washington</b> d. STREET ADDRESS <b>45 W St. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>WALTER J. PROCTER, Sr.</b> 4. DATE OF DEATH <b>October 27 1966</b>						5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>DEC. 28 1973</b> 9. AGE (In years last birthday) <b>92</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AWNING BUSINESS</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturing</b>						11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON D.C.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>WALTER PROCTER</b>						14. MOTHER'S MAIDEN NAME <b>XXXXXXXXXX Mary McKay</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>None</b>						16. SOCIAL SECURITY NO. <b>579-66-7500</b> 17. INFORMANT <b>Walter J. Procter, Jr.</b> Address <b>705 Birch Mills Ct. S. S., Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pleural Effusion Cause unknown</b> <b>0031</b> DUE TO (b) <b>Concurrent Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostate Reoperation 2 yrs ago. Cystitis</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1</b> , 19 <b>66</b> , to <b>27 Oct</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Oct 25</b> , 19 <b>66</b> , and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>M. B. Queen</b> 22b. DATE SIGNED <b>10/27/66</b>											
22c. PHYSICIAN'S NAME (Type) <b>M. B. QUEEN</b> 22d. ADDRESS <b>7112 Willow Ave Takoma Park, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Oct. 29, 1966</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>											
24. FUNERAL DIRECTOR <b>Clark E. Wisor</b> <b>Clank E. Wisor</b> <b>434 Georgia Ave.</b> 25a. REC'D BY REGISTRAR <b>DATE OCT 31 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											

参考文献